103D CONGRESS
1ST SESSION

S. 491

To provide health care for every American and to control the cost of the health care system.

IN THE SENATE OF THE UNITED STATES

MARCH 3, 1993

Mr. WELLSTONE (for himself, Mr. METZENBAUM, Mr. SIMON, and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide health care for every American and to control the cost of the health care system.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''American Health Security Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT

SEC. 101. ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM.

(a) IN GENERAL.—There is hereby established in the United States a State-based American Health Security Program to be administered by the individual States in accordance with Federal standards specified in, or established under, this Act.

(b) STATE HEALTH SECURITY PROGRAMS.—In order for a State to be eligible to receive payment under section 604, a State must establish a State health security program in accordance with this Act.

(c) STATE DEFINED.—

(1) IN GENERAL.—In this Act, subject to paragraph (2), the term ''State'' means each of the fifty States and the District of Columbia.

(2) ELECTION.—If the Governor of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands certifies to the President that the legislature of the Commonwealth or territory has enacted legislation desiring that the

Commonwealth or territory be included as a State under the provisions of this Act, such Commonwealth or territory shall be included as a ''State'' under this Act beginning January 1 of the first year beginning ninety days after the President receives the notification.

SEC. 102. UNIVERSAL ENTITLEMENT.

(a) IN GENERAL.—Every individual who is a resident of the United States and is a citizen or national of the United States or lawful resident alien (as defined in subsection (d) is entitled to benefits for health care services under this Act under the appropriate State health security program. In this section, the term ''appropriate State health security program'' means, with respect to an individual, the State health security program for the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The American Health Security Standards Board (in this Act referred to as the ''Board'') may make eligible for benefits for health care services under the appropriate State health security program under this Act such classes of aliens admitted to the United States as nonimmigrants as the Board may provide.

(2) CONSIDERATION.—In providing for eligibility under paragraph (1), the Board shall consider reciprocity in health care services offered to United States citizens who are nonimmigrants in other foreign states, and such other factors as the Board determines to be appropriate.

(c) TREATMENT OF OTHER INDIVIDUALS.—

(1) BY BOARD.—The Board also may make eligible for benefits for health care services under the appropriate State health security program under this Act other individuals not described in subsection (a) or (b), and regulate the nature of the eligibility of such individuals, in order—

(A) to preserve the public health of communities,

(B) to compensate States for the additional health care financing burdens created by such individuals, and

(C) to prevent adverse financial and medical consequences of uncompensated care,

while inhibiting travel and immigration to the United States for the sole purpose of obtaining health care services.

(2) BY STATES.—Any State health security program may make individuals described in paragraph (1) eligible for benefits at the expense of the State.

(d) LAWFUL RESIDENT ALIEN DEFINED.—For purposes of this section, the term ''lawful resident alien'' means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 234A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

SEC. 103. ENROLLMENT.

(a) IN GENERAL.—Each State health security program shall provide a mechanism for the enrollment of individuals entitled or eligible for benefits under this Act. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States and at the time of immigration into the United States or other acquisition of lawful resident status in the United States,

(2) provide for the enrollment, as of January 1, 1995, of all individuals who are eligible to be enrolled as of such date, and

(3) include a process for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 102.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall make applications for enrollment under the program available—

(1) at local offices of the Social Security Administration,

(2) at social services locations,

(3) at out-reach sites (such as provider and practitioner locations), and

(4) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual's enrollment for benefits under this Act, the State health security program shall provide for the issuance of a health security card which shall be used for purposes of identification and processing of claims for benefits under the program.

SEC. 104. PORTABILITY OF BENEFITS.

(a) IN GENERAL.—To ensure continuous access to benefits for health care services covered under this Act, each State health security program—

(1) shall not impose any minimum period of residence in the State, or waiting period, in excess of three months before residents of the State are entitled to, or eligible for, such benefits under the program;

(2) shall provide continuation of payment for covered health care services to individuals who have terminated their residence in the State and established their residence in another State, for the duration of any waiting period imposed in the State of new residency for establishing entitlement to, or eligibility for, such services; and

(3) shall provide for the payment for health care services covered under this Act provided to individuals while temporarily absent from the State, for reasons other than to obtain the services, based on the following principles:

(A) Payment for such health care services is at the rate that is approved by the State health security program in the State in which the services are provided, unless the States concerned agree to apportion the cost between them in a different manner.

(B)(i) Except as provided in clause (ii), payment for such health care services provided

outside the United States is made on the basis of the amount that would have been paid by the State health security program for similar services rendered in the State, with due regard, in the case of hospital services, to the size of the hospital, standards of service, and other relevant factors.

(ii) Payment for services described under clause (i) which are elective services shall be subject to prior consent of the agency that administers and operates the State health security program if such elective services are available on a substantially similar basis in the State.

(iii) For the purposes of this subparagraph, the term ''elective services'' means health care services covered under this Act other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

(b) CROSS-BORDER ARRANGEMENTS.—A State health security program for a State may negotiate with such a program in an adjacent State a reciprocal arrangement for the coverage under such other program of health care services to enrollees residing in the border region.

SEC. 105. EFFECTIVE DATE OF BENEFITS.

Benefits shall first be available under this Act for items and services furnished on or after January 1, 1995.

SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE AND MEDICAID.—

(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (2)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished after December 31, 1994,

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished after such date, and

(C) no payment shall be made to a State under section 1903(a) of such Act with respect to medical assistance for any item or service furnished after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 1995, and which had not ended as of such date, for which benefits are provided under title XVIII, or under a State plan under title XIX, of the

Social Security Act, the Secretary of Health and Human Services and each State plan, respectively, shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring after December 31, 1994.

(c) CHAMPUS.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished after December 31, 1994.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—Nothing in this Act shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG TERM CARE

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the succeeding provisions of this title, individuals enrolled for benefits under

this Act are entitled to have payment made under a State health security program for the following items and services if medically necessary and appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) HOSPITAL SERVICES.—Inpatient and outpatient hospital care, including 24-hour a day emergency services.

(2) PROFESSIONAL SERVICES.—Professional services of health care practitioners authorized to provide health care services under State law.

(3) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—Community-based primary health services (as defined in section 202(a)).

(4) PREVENTIVE SERVICES.—Preventive services (as defined in section 202(b)).

(5) LONG-TERM AND CHRONIC CARE SERVICES.—

(A) Nursing facility services.

(B) Home health services.

(C) Home and community-based long term care services (as defined in section 202(c)) for individuals described in section 203(a).

(D) Hospice care.

(6) PRESCRIPTION DRUGS, BIOLOGICALS, INSULIN, MEDICAL FOODS.—

(A) Outpatient prescription drugs and biologicals, as specified by the Board consistent with section 616.

(B) Insulin.

(C) Medical foods (as defined in section 202(d)).

(7) MENTAL HEALTH SERVICES.—Mental health services (as defined in section 202(e)), subject to the requirements of section 204(b).

(8) SUBSTANCE ABUSE TREATMENT SERVICES.—Substance abuse treatment services (as defined in section 202(f)), subject to the requirements of section 204(b).

(9) DIAGNOSTIC TESTS.—Diagnostic tests.

(10) OTHER ITEMS AND SERVICES.—

(A) OUTPATIENT THERAPY.—Outpatient physical therapy services, outpatient speech pathology services, and outpatient occupational therapy services in all settings.

(B) DURABLE MEDICAL EQUIPMENT.—Durable medical equipment.

(C) HOME DIALYSIS.—Home dialysis supplies and equipment.

(D) AMBULANCE.—Emergency ambulance service.

(E) PROSTHETIC DEVICES.—Prosthetic devices, including replacements of such devices.

(F) ADDITIONAL ITEMS AND SERVICES.—Such other medical or health care items or services as the Board may specify.

(b) NO COST-SHARING.—There are no deductibles, coinsurance, or copayments applicable to benefits provided under this title.

(c) PROHIBITION OF BALANCE BILLING.—As provided in section 631, no person may impose a charge for covered services for which benefits are provided under this Act.

(d) NO DUPLICATE HEALTH INSURANCE.—Each State health security program shall prohibit the sale of health insurance in the State if payment under the insurance duplicates payment for any items or services for which payment may be made under such a program.

(e) STATE PROGRAM MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this Act shall be construed as limiting the benefits that may be made available under a State health security program to residents of the State at the expense of the State.

(f) EMPLOYERS MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this Act shall be construed as limiting the additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

SEC. 202. DEFINITIONS RELATING TO SERVICES.

(a) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—In this title, the term ''community-based primary health services'' means ambulatory health services furnished—

(1) by a rural health clinic;

(2) by a Federally-qualified health center, and which, for purposes of this Act, include services furnished by State and local health agencies;

(3) in a school-based setting;

(4) by public educational agencies and other providers of services to children entitled to assistance under the Individuals with Disabilities Education Act for services furnished pursuant to a written Individualized Family Services Plan or Individual Education Plan under such Act; and

(5) public and private non-profit entities receiving Federal assistance under the Public Health Service Act.

(b) PREVENTIVE SERVICES.—

(1) IN GENERAL.—In this title, the term ''preventive services'' means items and services—

(A) which—

(i) are specified in paragraph (2), or

(ii) the Board determines to be effective in the maintenance and promotion of health and minimizing the effect of illness, disease, or medical condition or to be effective in preventing further deterioration due to disability; and

(B) which are provided consistent with the periodicity schedule established under paragraph (3).

(2) SPECIFIED PREVENTIVE SERVICES.—The services specified in this paragraph are as follows:

(A) Basic immunizations.

(B) Prenatal and well-baby care (for infants under one year of age).

(C) Well-child care (including periodic physical examinations, hearing and vision screening, and developmental screening and examinations) for individuals under 18 years of age.

(D) Periodic screening mammography, Pap smears, and colorectal examinations and examinations for prostate cancer.

(E) Routine dental examinations and prophylaxis.

(F) Physical examinations.

(G) Family planning services.

(H) Routine eye examinations, eyeglasses, and contact lenses.

(I) Hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

(3) SCHEDULE.—The Board shall establish, in consultation with experts in preventive medicine and public health and taking into consideration those preventive services recommended by the Preventive Services Task Force and published as the Guide to Clinical Preventive Services, a periodicity schedule for the coverage of preventive services under paragraph (1). Such schedule shall take into consideration the cost-effectiveness of appropriate preventive care and shall be revised not less frequently than

once every 5 years, in consultation with experts in preventive medicine and public health.

(c) HOME AND COMMUNITY-BASED LONG TERM CARE SERVICES.—In this title, the term ''home and community-based long term care services'' means services provided to an individual and to enable the individual to function independently to the extent possible and to remain in such individual's place of residence within the community and includes care coordination services (as defined in subsection (g)(1)).

(d) MEDICAL FOODS.—In this title, the term ''medical foods'' means foods which are formulated to be consumed or administered enterally under the supervision of a physician and which are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

(e) MENTAL HEALTH SERVICES.—In this title, the term ''mental health services'' means services related to the prevention, diagnosis, treatment, and rehabilitation of mental illness and promotion of mental health, including the following services:

(1) Crisis intervention.

(2) Outpatient mental health services.

(3) Partial hospitalization and day and evening treatment programs.

(4) Psychosocial rehabilitation services.

(5) Pharmacotherapeutic interventions.

(6) Other rehabilitation services, including halfway and three-quarter-way house care.

(7) Inpatient mental health services.

(8) Care coordination services (as defined in subsection (g)(1)).

(f) SUBSTANCE ABUSE TREATMENT SERVICES.—In this title, the term ''substance abuse treatment services'' means services related to the prevention, diagnosis, treatment, and rehabilitation of dependency on alcohol or controlled substances provided through a treatment program meeting State qualification standards and includes the following services:

(1) Crisis intervention, including assessment, diagnosis, and referral.

(2) Detoxification services, in ambulatory and inpatient settings.

(3) Outpatient services, including intensive day and evening programs, continuing care, and family services.

(4) Short-term residential services in a hospital or free-standing program.

(5) Long-term residential services, including therapeutic communities and halfway houses.

(6) Pharmacotherapeutic interventions.

(7) Care coordination services (as defined in subsection (g)(1)).

(g) CARE COORDINATION SERVICES.—

(1) DEFINITION.—

(A) IN GENERAL.—In this title, the term ''care coordination services'' means services provided by care coordinators (as defined in paragraph (2))—

(i) to individuals described in paragraph (3) for the coordination and monitoring of mental health services, substance abuse treatment services, and home and community-based long term care services, and

(ii) to individuals who require services to prevent secondary disabilities for the coordination and monitoring of home and community-based long term care services and preventive services,

to ensure appropriate, cost-effective utilization of such services in a comprehensive and contin-

uous manner, and includes the services described in subparagraph (B).

(B) SERVICES INCLUDED.—The services described in this subparagraph are—

(i) transition management between inpatient facilities and community-based services, including assisting patients in identifying and gaining access to appropriate ancillary services; and

(ii) evaluating and recommending appropriate treatment services, in cooperation with patients and other providers and in conjunction with any quality review program or plan of care under title V.

(2) CARE COORDINATOR.—

(A) IN GENERAL.—In this title, the term ''care coordinator'' means an individual or nonprofit or public agency or organization which the State health security program determines—

(i) is capable of performing directly, efficiently, and effectively the duties of a care coordinator described in paragraph (1), and

(ii) demonstrates capability in establishing and periodically reviewing and re-

vising plans of care, and in arranging for and monitoring the provision and quality of services under any plan.

(B) INDEPENDENCE.—State health security programs shall establish safeguards to assure that care coordinators have no financial interest in treatment decisions or placements. Care coordination may not be provided through any structure or mechanism through which utilization review is performed.

(3) ELIGIBLE INDIVIDUALS.—An individual described in this paragraph is an individual—

(A) described in section 203 (relating to individuals qualifying for long term and chronic care services); or

(B) determined (in a manner specified by the Board)—

(i) to have a serious mental illness (as defined by the Board), or

(ii) to have a history of substance abuse displaying severe associated illness or previous treatment failure (as defined by the Board).

(h) NURSING FACILITY; NURSING FACILITY SERVICES.—Except as may be provided by the Board, the

terms ''nursing facility'' and ''nursing facility services'' have the meanings given such terms in sections 1919(a) and 1905(f), respectively, of the Social Security Act.

(i) OTHER TERMS.—Except as may be provided by the Board, the definitions contained in section 1861 of the Social Security Act shall apply.

SEC. 203. SPECIAL RULES FOR HOME AND COMMUNITY-BASED LONG TERM CARE SERVICES.

(a) QUALIFYING INDIVIDUALS.—For purposes of section 201(a)(5)(C), individuals described in this subsection are the following individuals:

(1) ADULTS.—Individuals 18 years of age or older determined (in a manner specified by the Board)—

(A) to be unable to perform, without the assistance of an individual, at least 2 of the following 5 activities of daily living (or who has a similar level of disability due to cognitive impairment)—

(i) bathing;

(ii) eating;

(iii) dressing;

(iv) toileting; and

(v) transferring in and out of a bed or in and out of a chair; or

(B) due to cognitive or mental impairments, requires supervision because the individual behaves in a manner that poses health or safety hazards to himself or herself or others.

(2) CHILDREN.—Individuals under 18 years of age determined (in a manner specified by the Board) to meet such alternative standard of disability for children as the Board develops.

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—No individual is entitled to receive benefits under a State health security program with respect to home and community-based long term care services in a period (specified by the Board) to the extent the amount of payments for such benefits exceeds 65 percent (or such alternative ratio as the Board establishes under paragraph (2)) of the average of amount of payment that would have been made under the program during the period if the individual were a resident of a nursing facility in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long term care services to payments for nursing fa-

cility services) as the Board determines to be more consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting.

SEC. 204. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Subject to section 201(e), benefits for service are not available under this Act unless the services meet the standards specified in section 201(a).

(b) MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT SERVICES.—

(1) IN GENERAL.—Mental health services and substance abuse treatment services furnished for an individual in excess of a threshold specified in paragraph (2) are not covered services unless the services are determined under a utilization review program to meet the standards specified in section 201(a) and, with respect to inpatient or residential treatment services, to be provided in the least restrictive and most appropriate setting.

(2) UTILIZATION REVIEW THRESHOLD.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the thresholds specified in this paragraph are—

(i) 20 outpatient visits in a year, and

(ii) 15 days of inpatient services in a year.

(B) ALTERNATIVE NATIONAL THRESHOLDS.—The Board may specify alternative thresholds to those specified in subparagraph (A).

(C) ADDITIONAL STATE THRESHOLDS.—A State health security program may specify thresholds in addition to those established under the previous subparagraphs, which thresholds may be higher or lower than the number of outpatient visits or days of inpatient services otherwise specified.

(c) TREATMENT OF EXPERIMENTAL SERVICES.—In applying subsection (a), the Board shall make, after consultation with a technical advisory committee, national coverage determinations with respect to those services that are experimental in nature. Such determinations shall be made consistent with a process that provides for professional input and public comment.

(d) APPLICATION OF NATIONAL PRACTICE GUIDELINES.—In the case of services for which the Board has recognized national practice guidelines, the services are considered to meet the standards specified in section 201(a) only if they have been provided in accordance with

such guidelines or in accordance with such exceptions process as may be established by the Board consistent with such guidelines.

(e) SPECIFIC LIMITATIONS.—

(1) LIMITATIONS ON EYEGLASSES, CONTACT LENSES, HEARING AIDS, AND DURABLE MEDICAL EQUIPMENT.—Subject to section 201(e), the Board may impose such limits relating to the costs and frequency of replacement of eyeglasses, contact lenses, hearing aids, and durable medical equipment to which individuals enrolled for benefits under this Act are entitled to have payment made under a State health security program as the Board deems appropriate.

(2) OVERLAP WITH PREVENTIVE SERVICES.—The coverage of services described in section 201(a) (other than paragraph (3)) which also are preventive services are required to be covered only to the extent that they are required to be covered as preventive services.

(3) MISCELLANEOUS EXCLUSIONS FROM COVERED SERVICES.—Covered services under this Act do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic pur-

poses (as defined in regulations) and hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

(ii) required to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery; or

(iii) otherwise determined to be medically necessary and appropriate under section 201(a).

(B) Personal comfort items or private rooms in inpatient facilities, unless determined to be medically necessary and appropriate under section 201(a).

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(f) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—Nursing facility services and home health services (other than post-hospital services, as defined by the Board) furnished to an individual who is not described in section 203(a) are not covered services unless the services are determined to meet the standards speci-

fied in section 201(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

(g) SERVICES INVOLVING UNAPPROVED CAPITAL EXPENDITURES.—Benefits are not available under this Act with respect to a service which involves the use of equipment, facility, or plant if the capital expenditure for the equipment, facility, or plant was subject to, but was not approved under, the process described in section 605.

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this Act is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 302;

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this Act.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between a State health security program and a provider shall provide at least for the following:

(A) Services to eligible persons will be furnished by the provider without discrimination on the ground of race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition, or (subject to the professional qualifications of the provider) illness. Nothing in this subparagraph shall be construed as requiring the provision of a type or class of services which services are outside the scope of the provider's normal practice.

(B) No charge will be made for any covered services other than for payment authorized by this Act.

(C) The provider agrees to furnish such information as may be reasonably required by the Board or a State health security program, in accordance with uniform reporting standards established under section 401(g)(1), for—

(i) quality assurance and utilization review by professional peers and consumers;

(ii) the making of payments under this Act (including the examination of records as may be necessary for the verification of information on which payments are based);

(iii) statistical or other studies required for the implementation of this Act; and

(iv) such other purposes as the Board or State may specify.

(D) The provider agrees not to expend any amounts on capital expenditures (as defined in section 605(c)) relating to the provision of covered services unless the purchase of such items has been approved under section 605 and agrees not to bill the program for any services for which benefits are not available because of section 204(g).

(E) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider who or which has

had a participation agreement under this subsection terminated for cause.

(F) In the case of a provider paid under a fee-for-service basis under section 613, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered services within 30 days (or such shorter period as a State health security program may require) after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENTS.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Board or a State health security program for failure to meet the requirements of this title, or

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Board or a State health security program terminates an agreement unless a more immediate termi-

nation is required for public safety or similar reasons.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

(1) all the requirements of State law to provide such services,

(2) applicable requirements of Federal law to provide such services, and

(3) any applicable standards established under subsection (b).

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Board shall establish, evaluate, and update national minimum standards to assure the quality of services provided under this Act and to monitor efforts by State health security programs to assure the quality of such services. A State health security program may also establish additional minimum standards which providers must meet.

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services, individual health care practitioners, and comprehen-

sive health service organizations. Except as the Board may specify in order to carry out this title, a hospital, nursing facility, or other institutional provider of services shall meet standards (including having in effect a utilization review plan) for such a facility under the medicare program under title XVIII of the Social Security Act. Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction (including waiting time and access to services); and

(F) performance standards (including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation).

(3) TRANSITION IN APPLICATION.—If the Board provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that

provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) EXCHANGE OF INFORMATION.—The Board shall provide for an exchange, at least annually, among State health security programs of information with respect to quality assurance and cost containment.

SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—For purposes of this Act, a comprehensive health service organization (in this section referred to as a ''CHSO'') is a public or private organization which, in return for payment under section 613(a), undertakes to furnish, arrange for the provision of, or provide payment with respect to—

(1) a full range of health services (as identified by the Board), including at least hospital services and physicians services, and

(2) out-of-area coverage in the case of urgently needed services,

to an identified population which is living in or near a specified service area and which enrolls voluntarily in the organization.

(b) ENROLLMENT.—

(1) IN GENERAL.—All eligible persons living in or near the specified service area of a CHSO are eligible to enroll in the organization; except that the number of enrollees may be limited to avoid overtaxing the resources of the organization.

(2) MINIMUM ENROLLMENT PERIOD.—Subject to paragraph (3), the minimum period of enrollment with a CHSO shall be twelve months, unless the enrolled individual becomes ineligible to enroll with the organization.

(3) WITHDRAWAL FOR CAUSE.—Each CHSO shall permit an enrolled individual to disenroll from the organization for cause at any time.

(4) BROAD MARKETING.—Each CHSO must provide for the marketing of its services (including dissemination of marketing materials) to potential enrollees in a manner that is designed to enroll individuals representative of the different population groups and geographic areas included within its service area and meets such requirements as the Board or a State health security program may specify.

(c) REQUIREMENTS FOR CHSOS.—

(1) ACCESSIBLE SERVICES.—Each CHSO, to the maximum extent feasible, shall make all services

readily and promptly accessible to enrollees who live in the specified service area.

(2) CONTINUITY OF CARE.—Each CHSO shall furnish services in such manner as to provide continuity of care and (when services are furnished by different providers) shall provide ready referral of patients to such services and at such times as may be medically appropriate.

(3) BOARD OF DIRECTORS.—In the case of a CHSO that is a private organization—

(A) CONSUMER REPRESENTATION.—At least one-third of the members of the CHSO's board of directors must be consumer members with no direct or indirect, personal or family financial relationship to the organization.

(B) PROVIDER REPRESENTATION.—The CHSO's board of directors must include at least one member who represents health care providers.

(4) PATIENT GRIEVANCE PROGRAM.—Each CHSO must have in effect a patient grievance program and must conduct regularly surveys of the satisfaction of members with services provided by or through the organization.

(5) HEALTH EDUCATION.—Each CHSO must encourage health education of its enrollees and the development and use of preventive health services, health promotion and wellness, self-care, and, if applicable, independent living arrangements.

(6) MEDICAL STANDARDS.—Each CHSO must provide that a committee or committees of health care practitioners associated with the organization will promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the quality of all health services (including drugs, education, and preventive services).

(7) USE OF ALLIED HEALTH PROFESSIONALS.—Each CHSO must, to the extent practicable and consistent with good medical practice, employ allied health personnel and paraprofessional persons in the furnishing of services.

(8) PREMIUMS.—Premiums or other charges by a CHSO for any services not paid for under this Act must be reasonable.

(9) UTILIZATION AND BONUS INFORMATION.—Each CHSO must—

(A) comply with the requirements of section 1876(i)(8) of the Social Security Act (relating to prohibiting physician incentive plans that provide specific inducements to reduce or limit medically necessary services), and

(B) make available to its membership utilization information and data regarding financial performance, including bonus or incentive payment arrangements to practitioners.

(10) PROVISION OF SERVICES TO ENROLLEES AT INSTITUTIONS OPERATING UNDER GLOBAL BUDGETS.—The organization shall arrange to reimburse for hospital services and other facility-based services (as identified by the Board) for services provided to members of the organization in accordance with the global operating budget of the hospital or nursing facility approved under section 611.

(11) LIMITATION ON CAPITAL EXPENDITURES.—The organization agrees—

(A) not to expend any amounts on capital expenditures (as defined in section 605(c)) relating to the provision of covered services unless the purchase of such items has been approved under section 605,

(B) that any amounts attributable to a reasonable rate of return on equity capital shall not be used for any capital expenditures, and

(C) agrees not to bill the program for any services for which benefits are not available because of section 204(g).

(12) ADDITIONAL REQUIREMENTS.—Each CHSO must meet—

(A) such requirements relating to minimum enrollment,

(B) such requirements relating to financial solvency,

(C) such requirements relating to quality and availability of care, and

(D) such other requirements,

as the Board or a State health security program may specify.

(d) PROVISION OF EMERGENCY SERVICES TO NONENROLLEES.—A CHSO may furnish emergency services to persons who are not enrolled in the organization. Payment for such services, if they are covered services to eligible persons, shall be made to the organization unless the organization requests that it be made to the individual practitioner who furnished the services.

SEC. 304. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.

(a) APPLICATION TO AMERICAN HEALTH SECURITY PROGRAM.—Section 1877 of the Social Security Act, as amended by subsections (b) and (c), shall apply under this Act in the same manner as it applies under title XVIII of the Social Security Act; except that in applying such section under this Act any references in such section to the Secretary or title XVIII of the Social Security Act are deemed references to the Board and the American Health Security Program under this Act, respectively.

(b) EXPANSION OF PROHIBITION TO CERTAIN DESIGNATED SERVICES.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) by striking ''clinical laboratory services'' and ''CLINICAL LABORATORY SERVICES'' and inserting ''designated health services'' and ''DESIGNATED HEALTH SERVICES'', respectively, each place either appears in subsections (a)(1), (b)(2)(A)(ii)(I), (b)(4), (d)(1), (d)(2), and (d)(3);

(2) by adding at the end of such section the following new subsection:

''(i) DESIGNATED HEALTH SERVICES DEFINED.—In this section, the term 'designated health services' means—

''(1) clinical laboratory services;

''(2) physical therapy services;

''(3) radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services;

''(4) radiation therapy services;

''(5) the furnishing of durable medical equipment;

''(6) the furnishing of parenteral and enteral nutrition equipment and supplies;

''(7) the furnishing of outpatient prescription drugs;

''(8) ambulance services;

''(9) home infusion therapy services;

''(10) occupational therapy services;

''(11) inpatient and outpatient hospital services (including services furnished at a psychiatric or rehabilitation hospital); and

''(12) other services or technologies as defined by the American Health Security Standards Board.'';

(3) in subsection (d)(2), by striking ''laboratory'' and by inserting ''entity'';

(4) in subsection (g)(1), by striking ''clinical laboratory service'' and by inserting ''designated health service''; and

(5) in subsection (h)(7)(B), by striking ''clinical laboratory service'' and by inserting ''designated health service''.

(c) CONFORMING AMENDMENTS.—Such section is further amended—

(1) in subsection (a)(1)(A), by striking ''for which payment otherwise may be made under this title'' and by inserting ''for which a charge is imposed'';

(2) in subsection (a)(1)(B), by striking ''under this title'';

(3) by amending paragraph (1) of subsection (g) to read as follows:

''(1) DENIAL OF PAYMENT.—No payment may be made under a State health security program for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third party payor, or other entity is liable for payment for designated health services for which a claim is presented in violation of such subsection.''; and

(4) In subsection (g)(3), by striking ''for which payment may not be made under paragraph (1)'' and by inserting ''for which such a claim may not be presented under subsection (a)(1)''.

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

SEC. 401. AMERICAN HEALTH SECURITY STANDARDS BOARD.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Standards Board.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Board shall be composed of—

(A) the Secretary of Health and Human Services, and

(B) 6 other individuals (described in paragraph (2)) appointed by the President with the advice and consent of the Senate.

The President shall first nominate individuals under subparagraph (B) on a timely basis so as to provide for the operation of the Board by not later than January 1, 1994.

(2) SELECTION OF APPOINTED MEMBERS.—With respect to the individuals appointed under paragraph (1)(B):

(A) They shall be chosen on the basis of backgrounds in health policy, health economics,

the healing professions, and the administration of health care institutions.

(B) They shall provide a balanced point of view with respect to the various health care interests and at least two of them shall represent the interests of individual consumers.

(C) Not more than three of them shall be from the same political party.

(3) TERMS OF APPOINTED MEMBERS.—Individuals appointed under paragraph (1)(B) shall serve for a term of 6 years, except that the terms of 5 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, 4, and 5 years. During a term of membership on the Board, no member shall engage in any other business, vocation or employment.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Board in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the re-

mainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint an appointed member of the Board for a second term in the same manner as the original appointment. A member who has served for two consecutive 6-year terms shall not be eligible for reappointment until two years after the member has ceased to serve.

(4) REMOVAL FOR CAUSE.—Upon confirmation, members of the Board may not be removed except by the President for cause.

(d) CHAIR.—The President shall designate one of the members of the Board, other than the Secretary, to serve at the will of the President as Chair of the Board.

(e) COMPENSATION.—Members of the Board (other than the Secretary) shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE BOARD.—

(1) IN GENERAL.—The Board shall develop policies, procedures, guidelines, and requirements to carry out this Act, including those related to—

(A) eligibility;

(B) enrollment;

(C) benefits;

(D) provider participation standards and qualifications, as defined in title III;

(E) national and State funding levels;

(F) methods for determining amounts of payments to providers of covered services, consistent with subtitle B of title VI;

(G) the determination of medical necessity and appropriateness (including the coverage of new technologies and the application of medical practice guidelines);

(H) quality assurance;

(I) assisting State health security programs with planning for capital expenditures and service delivery;

(J) planning for health professional education funding (as specified in title VII);

(K) allocating funds provided under title VII; and

(L) encouraging States to develop regional planning mechanisms (described in section 405(a)(3)).

(2) REGULATIONS.—Regulations authorized by this Act shall be issued by the Board in accordance

with the provisions of section 553 of title 5, United States Code.

(g) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Board shall establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. Such standards shall include, to the maximum extent feasible, health outcome measures.

(B) REPORTS.—The Board shall analyze regularly information reported to it, and to State health security programs pursuant to such requirements and standards.

(2) ANNUAL REPORT.—Beginning January 1, of the second year beginning after the date of the enactment of this Act, the Board shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

(E) Cost-containment measures and achievements under this Act.

(F) Quality assurance.

(G) The planning and approval process for determining capital expenditures under this Act, and the effects of decisions made under this provision.

(H) Health care utilization patterns, including any changes attributable to the program.

(I) Long-range plans and goals for the delivery of health services.

(J) Differences in the health status of the populations of the different States, including income and racial characteristics.

(K) Necessary changes in the education of health personnel.

(L) Plans for improving service to medically underserved populations.

(M) Transition problems as a result of implementation of this Act.

(N) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Board may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, state, or local basis, of any aspect of the operation of this Act, including studies of the effect of the Act upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(B) develop and test methods of providing through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy, access, and quality; methods of consumer and peer review and peer control of the utilization of drugs, of laboratory services, and of other services; and methods of consumer and peer review of the quality of services;

(C) develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administra-

tion, and develop and test model systems for use by providers of services;

(D) develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of preventive or diagnostic services;

(E) develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(F) make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act.

(4) REPORT ON USE OF EXISTING FEDERAL HEALTH CARE FACILITIES.—Not later than one year after the date of the enactment of this Act, the Board shall recommend to the Congress one or more proposals for the treatment of health care facilities of the Federal Government.

(h) EXECUTIVE DIRECTOR.—

(1) APPOINTMENT.—There is hereby established the position of Executive Director of the

Board. The Director shall be appointed by the Board and shall serve as secretary to the Board and perform such duties in the administration of this title as the Board may assign.

(2) DELEGATION.—The Board is authorized to delegate to the Director or to any other officer or employee of the Board or, with the approval of the Secretary of Health and Human Services (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department of Health and Human Services, any of its functions or duties under this Act other than—

(A) the issuance of regulations; or

(B) the determination of the availability of funds and their allocation to implement this Act.

(3) COMPENSATION.—The Executive Director of the Board shall be entitled to compensation at a level equivalent to level III of the Executive Schedule, in accordance with section 5314 of title 5, United States Code.

(i) INSPECTOR GENERAL.—The Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(1) in section 11(1) by inserting after ''Corporation;'' the following: ''the Chair of the American Health Security Standards Board;'';

(2) in section 11(2) by inserting after ''Information Agency,'' the following: ''the American Health Security Standards Board,''; and

(3) by inserting after section 8F the following:

''§ 8G. Special provisions concerning American Health Security Standards Board

''The Inspector General of the American Health Security Standards Board, in addition to the other authorities vested by this Act, shall have the same authority, with respect to the Board and the American Health Security Program under this Act, as the Inspector General for the Department of Health and Human Services has with respect to the Secretary of Health and Human Services and the medicare and medicaid programs, respectively.''.

(j) STAFF.—The Board shall employ such staff as the Board may deem necessary.

(k) ACCESS TO INFORMATION.—The Secretary of Health and Human Services shall make available to the Board all information available from sources within the Department or from other sources, pertaining to the duties of the Board.

SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUNCIL.

(a) IN GENERAL.—The Board shall provide for an American Health Security Advisory Council (in this section referred to as the ''Council'') to advise the Board on its activities.

(b) MEMBERSHIP.—The Council shall be composed of—

(1) the Chair of the Board, who shall serve as Chair of the Council, and

(2) twenty members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall include, in accordance with subsection (e), individuals who are representative of State health security programs, public health professionals, providers of health services, and of individuals (who shall constitute a majority of the Council) who are representative of consumers of such services, including a balanced representation of employers, unions, consumer organizations, and population groups with special health care needs.

(c) TERMS OF MEMBERS.—Each appointed member shall hold office for a term of four years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year, and five at the end of the fourth year after the date of enactment of this Act.

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may reappoint an appointed member of the Council for a second term in the same manner as the original appointment.

(e) QUALIFICATIONS.—

(1) PUBLIC HEALTH REPRESENTATIVES.—Members of the Council who are representative of State health security programs and public health professionals shall be individuals who have extensive experience in the financing and delivery of care under public health programs.

(2) PROVIDERS.—Members of the Council who are representative of providers of health care shall be individuals who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health practitioners.

(3) CONSUMERS.—Members who are representative of consumers of such care shall be individuals, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the consumption of such services.

(f) DUTIES.—

(1) IN GENERAL.—It shall be the duty of the Council—

(A) to advise the Board on matters of general policy in the administration of this Act, in

the formulation of regulations, and in the performance of the Board's duties under section 401; and

(B) to study the operation of this Act and the utilization of health services under it, with a view to recommending any changes in the administration of the Act or in its provisions which may appear desirable.

(2) REPORT.—The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board shall promptly transmit the report to the Congress, together with a report by the Board on any recommendations of the Council that have not been followed.

(g) STAFF.—The Council, its members, and any committees of the Council shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(h) MEETINGS.—The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request by seven or more members it shall be the duty of the Chair to call a meeting of the Council.

(i) COMPENSATION.—Members of the Council shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(j) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Council.

SEC. 403. PROFESSIONAL, TECHNICAL, AND TEMPORARY ADVISORY COMMITTEES.

(a) IN GENERAL.—The Board shall appoint the standing advisory committees specified in subsections (b) through (g), and such other standing professional and technical committees in order to advise it in carrying out its duties under this Act.

(b) ADVISORY COMMITTEE ON BENEFITS.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Benefits to advise it with respect to the several classes of covered services under this Act.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) drawn from the health professions, from consumers of health services, from providers of health services (including non-medical

licensed and non-licensed providers), or from other sources, whom the Board deems best qualified to advise it with respect to the professional and technical aspects of the furnishing and utilization of, and the evaluation of, a class of covered services designated by the Board, and with respect to the relationship of that class of services to other covered services. In appointing such individuals, the Board shall assure significant representation of consumers of health services and providers of health services.

(c) ADVISORY COMMITTEE ON COST CONTAINMENT.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Cost Containment to advise it with respect to the payments and cost containment measures contained in title VI of this Act.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) with national recognition for their expertise in health economics, health care financing, provider reimbursement, and related fields. In appointing individuals the Board shall assure significant representation of consumers of health services and providers of health services.

(d) ADVISORY COMMITTEE ON PRIMARY CARE AND THE MEDICALLY UNDERSERVED.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Primary Care and the Medically Underserved to advise it with respect to title VII of this Act, including with respect to the delivery of services and the education and training of health professionals, and to consider means of increasing the supply and expanding the scope of practice of mid-level professionals and the use of community health outreach workers and other non-professional health care workers.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) from the health professions and health services with expertise in—

(A) primary care services;

(B) the education and training of primary care practitioners;

(C) the special health needs of medically underserved populations;

(D) the training, educational, and financial incentives that would encourage health practitioners to serve in medically underserved areas;

(E) the delivery of health services through community-based and public facilities; and

(F) developing alternative models of delivering primary health services to medically underserved populations.

In appointing such individuals, the Board shall assure significant representation of consumers of health services and providers of health services.

(e) ADVISORY COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Mental Health and Substance Abuse Treatment Services to advise it with respect to the manner in which the benefits under this Act for mental health services and substance abuse treatment services should be modified to best meet the objectives of this Act.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) with expertise in health care economics, who are representative of the multi-disciplinary range of providers of such services, who are consumers of such services, and who represent advocacy groups representing consumers of such services.

(3) RESPONSIBILITIES.—The committee shall—

(A) study changes in the utilization patterns and costs which accompany the provision of mental health services and substance abuse treatment services;

(B) study and make recommendations on any changes that may be advisable in the utilization review thresholds specified in section 204(b)(2)(A);

(C) make recommendations on ways to create a continuum of care and encourage the provision of care in the least restrictive appropriate setting;

(D) develop a standard set of practices for care coordination services, including—

(i) the range of care coordination services that should be offered for a specific target population,

(ii) the organizational structure in which care coordination services should be based,

(iii) the minimum training requirements for care coordinators, and

(iv) the standards for the clinical necessity of care coordination services,

and study (and make recommendations concerning) peer care coordination services; and

(E) report any initial recommendations to the Board by January 1, 1995.

(4) ROLE OF SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—The Board shall consult with the Administrator of the Substance Abuse and Mental Health Services Administration in the appointment of members to, and operation of, the committee.

(f) ADVISORY COMMITTEE ON PRESCRIPTION DRUGS.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Prescription Drugs to advise it with respect to the classification of prescription drugs and biologicals under section 616(a)(1) and other matters relating to the coverage of prescription drugs under this Act.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The membership of the committee shall include individuals (in such number as the Board may determine) with expertise in appropriate utilization of prescription and nonprescription drug and biological thera-

pies and of the relative safety and efficacy of prescription drugs and biologicals.

(B) AREAS OF EXPERTISE.—A majority of the members of the committee shall be physicians. Members of the committee shall include at least a dentist, a nurse, and a pharmacist, and individuals with special knowledge or expertise in at least the following areas: geriatric, obstetric, pediatric, psychiatric, and neurological problems associated with drug therapies; clinical pharmacology; pharmacoepidemiology; and comparative clinical trials of drugs (including statisticians and biopharmaceutic specialists).

(C) CONFLICT OF INTEREST PROHIBITION.—No individual who is an employee of a manufacturer of a drug or biological or who otherwise has a material financial interest directly or indirectly with respect to such a manufacturer, or who has an immediate family member (as defined by the Board) who is such an employee or has such an interest, shall serve as a member of the committee.

(3) RESPONSIBILITIES.—The committee shall—

(A) continuously review scientific and medical information pertaining to the relative safety

and efficacy, and the comparability, of prescription drugs and biologicals approved for marketing in the United States; and

(B) recommend drug use classifications and identify, within such a classification, drugs that are therapeutic alternates for a given indication and indications for which particular drugs are superior based on safety and efficacy.

The committee is not authorized to engage in drug price negotiations nor define acceptable costs for any product.

(4) CONSUMER INPUT.—In conducting its activities, the committee shall solicit advice and comments from a panel of consumer advocates.

(g) ADVISORY COMMITTEE ON REHABILITATION AND CHRONIC CARE MANAGEMENT.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Rehabilitation and Chronic Care Management to advise the Board on ways to increase the effectiveness and efficiency of rehabilitation and chronic care management in the health care system.

(2) MEMBERSHIP.—The membership of the committee shall include rehabilitation professionals, consumers, and health policy professionals.

(h) TEMPORARY COMMITTEES.—The Board is authorized to appoint such temporary professional and technical committees as it deems necessary to advise it on special problems not encompassed in the assignments of standing committees appointed under this section or to supplement the advice of standing committees.

(i) REPORTING.—Committees appointed under this section shall report from time to time (but not less often than biannually) to the Board, and copies of their reports shall be transmitted by the Board to the American Health Security Advisory Council and be made readily available to the public.

(j) COMPENSATION.—All members of the committees established under this section shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(k) ADVICE FROM PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, PRACTITIONER PAYMENT REVIEW COMMISSION, ETC.—For provisions relating to role of certain commissions in reviewing payment rates, see section 620.

SEC. 404. AMERICAN HEALTH SECURITY QUALITY COUNCIL.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Quality Council.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Council shall be composed of 10 members appointed by the President. The President shall first appoint individuals on a timely basis so as to provide for the operation of the Council by not later than January 1, 1994.

(2) SELECTION OF MEMBERS.—The majority of members of the Council shall be members of a health profession. No more than five members of the Council shall be physicians. Physician members of the Council shall be appointed to the Council on the basis of national reputations for clinical and academic excellence. In appointing individuals, the President shall assure significant representation of consumers of health services.

(3) TERMS OF MEMBERS.—Individuals appointed to the Council shall serve for a term of 5 years, except that the terms of 4 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, and 4 years.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint a member of the Council for a second term in the same manner as the original appointment. A member who has served for two consecutive 5-year terms shall not be eligible for reappointment until two years after the member has ceased to serve.

(d) CHAIR.—The President shall designate one of the members of the Council to serve at the will of the President as Chair of the Council.

(e) COMPENSATION.—Members of the Council who are not employees of the Federal Government shall be entitled to compensation at a level equivalent to level III of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE COUNCIL.—The Council is responsible for quality review activities under title

V. The Council shall report to the Board annually on the conduct of activities under such title.

SEC. 405. STATE HEALTH SECURITY PROGRAMS.

(a) SUBMISSION OF PLANS.—

(1) IN GENERAL.—Each State shall submit to the Board a plan for a State health security program for providing for health care services to the residents of the State in accordance with this Act.

(2) REGIONAL PROGRAMS.—A State may join with one or more neighboring States to submit to the Board a plan for a regional health security program instead of separate State health security programs.

(3) REGIONAL PLANNING MECHANISMS.—The Board shall provide incentives for States to develop regional planning mechanisms to promote the rational distribution of, adequate access to, and efficient use of, tertiary care facilities, equipment, and services.

(b) REVIEW AND APPROVAL OF PLANS.—

(1) IN GENERAL.—The Board shall review plans submitted under subsection (a) and determine whether such plans meet the requirements for approval. The Board shall not approve such a plan unless it finds that the plan (or State law) provides,

consistent with the provisions of this Act, for the following:

(A) Payment for required health services for eligible individuals in the State in accordance with this Act.

(B) Establishment of a State Health Security Advisory Council, in accordance with subsection (d).

(C) Adequate administration, including the designation of a single State agency responsible for the administration (or supervision of the administration) of the program.

(D) The establishment of a State health security budget and establishment of an approval process for capital expenditures.

(E) Establishment of payment methodologies (consistent with subtitle B of title VI).

(F) Assurances that individuals have the freedom to choose practitioners and other health care providers for services covered under this Act.

(G) A procedure for carrying out long-term regional management and planning functions, including establishment of District Health Advisory Councils in accordance with section 406,

with respect to the delivery and distribution of health care services that—

(i) ensures participation of consumers of health services and providers of health services,

(ii) takes into account the recommendations of District Health Advisory Councils under section 406, and

(iii) gives priority to the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the delivery of covered services and to the means for the speedy alleviation of these shortcomings, and

(iv) encourages the integration of preventive public health and primary care services, incorporating epidemiologic data and community-based clinical results.

(H) The licensure and regulation of all health providers and facilities to ensure compliance with Federal and State laws and to promote quality of care.

(I) Establishment of a quality review system in accordance with section 502.

(J) Establishment of an independent ombudsman for consumers to register complaints about the organization and administration of the State health security program and to help resolve complaints and disputes between consumers and providers.

(K) Publication of an annual report on the operation of the State health security program, which report shall include information on cost, progress towards achieving full enrollment, public access to health services, quality improvement, health outcomes, health professional training, and the needs of medically underserved populations.

(L) Provision of a fraud and abuse prevention and control unit that the Inspector General determines meets the requirements of section 413(a).

(M) Provision that—

(i) all claims or requests for payment for services shall be accompanied by the unique provider identifier assigned under section 414(a) to the provider and the unique patient identifier assigned to the individual under section 414(b);

(ii) no payment shall be made under the program for the provision of health care services by any provider unless the provider has furnished the program with the unique provider identifier assigned under section 414(a);

(iii) the plan shall use the unique patient identifier assigned under section 414(b) to an individual as the identifier of the individual in the processing of claims and other purposes (as specified by the Board); and

(iv) queries made under section 412(c)(2) shall be made using the unique provider identifier specified under section 414(a).

(N) Prohibit payment in cases of prohibited physician referrals under section 304.

(O) Effective January 1, 2000, provide for use of a uniform electronic data base in accordance with section 504(a).

(2) CONSEQUENCES OF FAILURE TO COMPLY.—If the Board finds that a State plan submitted under paragraph (1) does not meet the requirements for approval under this section or that a State

health security program or specific portion of such program, the plan for which was previously approved, no longer meets such requirements, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period specified by the Board, the Board shall place the State health security program (or specific portions of such program) in receivership under the jurisdiction of the Board.

(c) STATE HEALTH SECURITY ADVISORY COUNCILS.—

(1) IN GENERAL.—For each State, the Governor shall provide for appointment of a State Health Security Advisory Council to advise and make recommendations to the Governor and State with respect to the implementation of the State health security program in the State.

(2) MEMBERSHIP.—Each State Health Security Advisory Council shall be composed of at least 11 individuals. The appointed members shall include individuals who are representative of the State health security program, public health professionals, providers of health services, and of individuals (who shall constitute a majority) who are representative of consumers of such services, including a balanced rep-

resentation of employers, unions and consumer organizations.

(3) DUTIES.—

(A) IN GENERAL.—Each State Health Security Advisory Council shall review, and submit comments to the Governor concerning the implementation of the State health security program in the State.

(B) ASSISTANCE.—Each State Health Security Advisory Council shall provide assistance and technical support to community organizations and public and private non-profit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation.

(d) STATE USE OF FISCAL AGENTS.—

(1) IN GENERAL.—Each State health security program, using competitive bidding procedures, may enter into such contracts with qualified entities, such as voluntary associations, as the State determines to be appropriate to process claims and to perform other related functions of fiscal agents under the State health security program.

(2) RESTRICTION.—Except as the Board may provide for good cause shown, in no case may more than one contract described in paragraph (1) be entered into under a State health security program.

SEC. 406. DISTRICT HEALTH ADVISORY COUNCILS.

(a) IN GENERAL.—Subject to subsection (d), each State health security program shall establish district health advisory councils covering distinct geographic areas for the purposes of—

(1) advising and making recommendations to the State with respect to implementation of the program in the geographic area served by a council;

(2) receiving and investigating complaints by eligible persons and by providers of services concerning the administration of the program and of taking or recommending appropriate corrective action; and

(3) carrying out district management and planning functions with the State health security program, including—

(A) assessing the health needs of the district;

(B) assessing the quality, supply, and distribution of health resources, including acute care hospitals, specialized inpatient facilities, outpatient facilities, trained health care person-

nel, the availability of specialized medical equipment, and home and community-based health programs;

(C) assessing the need for services to medically underserved areas to achieve equitable access to care;

(D) advising on restructuring the health delivery system, including reductions in excess capacity, shifting from institutional to ambulatory care, and other means of achieving efficiencies;

(E) advising on funding for new and expanded programs, including capital expenditures;

(F) meeting at least biannually with representatives of the State health security program (i) to determine the goals and priorities for meeting health care needs and (ii) to plan for the efficient and effective use of health resources within the district; and

(G) establishing a strategy to implement such goals and priorities.

(b) MEMBERSHIP.—Each district health advisory council shall be composed of individuals, appointed by the Governor of the State, who include representatives of local

public health programs, public health professionals, providers of health services, and of persons (who shall constitute a majority) who are representative of consumers of such services, including a balanced representation of employers, unions, and consumer organizations and population groups with special health needs. The Governor shall consult with the State Health Security Advisory Council and local officials in the appointment of district health advisory councils.

(c) GRANT ASSISTANCE.—Each district health advisory council shall provide assistance and technical support to community organizations and public and private nonprofit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation.

(d) USE OF STATE HEALTH SECURITY ADVISORY COUNCIL.—

(1) IN GENERAL.—Subject to paragraph (2), the Board may waive the requirement that a State establish district health advisory councils if the State demonstrates to the satisfaction of the Board that—

(A) the establishment of such councils in the State is unnecessary because of the State's size or population;

(B) the membership of the State Health Security Advisory Council established under section 405(d) is consistent with the requirements for membership of such a council under subsection (b); and

(C) such Council will perform the functions of a district health advisory council under subsections (a) and (c).

(2) PERFORMANCE OF COUNCIL FUNCTIONS.—If the Board waives requirements with respect to a State under paragraph (1), the State Health Security Advisory Council shall perform, with respect to the entire State, the functions of a district health advisory council under subsections (a) and (c).

SEC. 407. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary of Health and Human Services shall direct all activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER AMERICAN HEALTH SECURITY PROGRAM.

The following sections of the Social Security Act shall apply to State health security programs in the same manner as they apply to State medical assistance plans under title XIX of such Act (except that in applying such provisions any reference to the Secretary is deemed a reference to the Board):

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

SEC. 412. NATIONAL HEALTH CARE FRAUD DATA BASE.

(a) ESTABLISHMENT.—The American Health Security Standards Board, through the Inspector General, shall establish a national data base (in this section referred to as the ''data base'') containing information relating to health care fraud and abuse.

(b) DATA INCLUDED.—

(1) IN GENERAL.—The data base shall include such information as the Inspector General, in consultation with the Board, shall specify, and shall include at least the information described in paragraph (2).

(2) SPECIFIED INFORMATION.—The information specified in this paragraph is, with respect to providers of health care services, the identity of any provider—

(A) that has been convicted of a crime for which the provider may be excluded from participation under a health program (as defined in paragraph (3));

(B) whose license to provide health care has been revoked or suspended (as described in section 1128(b)(5) of the Social Security Act);

(C) that has been excluded or suspended from a health program under section 1128 of the Social Security Act or from any other Federal or State health care program;

(D) with respect to whom a civil money penalty has been imposed under this Act or the Social Security Act; or

(E) that otherwise is subject to exclusion from participation under a health program .

(3) HEALTH PROGRAM DEFINED.—In this section, the term ''health program'' means a State health security program and includes the medicare program (under title XVIII of the Social Security Act) and a State health care program (as defined in section 1128(h) of such Act).

(c) REPORTING REQUIREMENT.—

(1) REPORTING.—Each State health security program shall provide such information to the Inspector General as the Inspector General may require in order to carry out fraud and abuse control activities and for purposes of maintaining the data base.

(2) QUERYING.—In accordance with rules established by the Board (in consultation with the Inspector General), each State health security program shall query periodically (as specified by the Inspector General)—

(A) the data base to determine if providers of health services for which the program makes payment are not disqualified from providing such services, and

(B) the Secretary of Health and Human Services, concerning information obtained by the Secretary under part B of the Health Care Quality Improvement Act of 1986 relating to practitioners.

(3) COORDINATION WITH MALPRACTICE DATA BASE.—The Secretary of Health and Human Services shall provide for the coordination of the reporting and disclosure of information under this section with information under part B of the Health Care Quality Improvement Act of 1986.

(4) UNIFORM MANNER.—Information shall be reported under this subsection in a uniform manner (in accordance with standards of the Inspector General) that permits aggregation of reported information.

(5) ACCESS FOR AUDIT.—Each State health security program shall provide the Inspector General such access to information as may be required to verify the information reported under this subsection.

(6) PENALTY FOR FALSE INFORMATION.—Any person that submits false information required to be provided under this subsection or that denies access to information under paragraph (5) may be impris-

oned for not more than 5 years, or fined, or both, in accordance with title 18, United States Code.

(7) CONFIDENTIALITY.—The Board shall establish rules that protect the confidentiality of the information in the data base.

SEC. 413. REQUIREMENTS FOR OPERATION OF STATE HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) REQUIREMENT.—In order to meet the requirement of section 405(b)(1)(L), each State health security program must establish and maintain a health care fraud and abuse control unit (in this section referred to as a ''fraud unit'') that meets requirements of this section and other requirements of the Board. Such a unit may be a State medicaid fraud control unit (described in section 1903(q) of the Social Security Act).

(b) STRUCTURE OF UNIT.—The fraud unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from the State agency with principal responsibility for the administration of the State health security program; and

(3) meet 1 of the following requirements:

(A) It must be a unit of the office of the State Attorney General or of another depart-

ment of State government which possesses statewide authority to prosecute individuals for criminal violations.

(B) If it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Board, that (i) assure its referral of suspected criminal violations relating to the State health insurance plan to the appropriate authority or authorities in the States for prosecution, and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions.

(C) It must have a formal working relationship with the office of the State Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Board and which provide effective coordination of activities between the fraud unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the State health insurance plan.

(c) FUNCTIONS.—The fraud unit must—

(1) have the function of conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of health care services and activities of providers of such services under the State health security program;

(2) have procedures for reviewing complaints of the abuse and neglect of patients of providers and facilities that receive payments under the State health security program, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action; and

(3) provide for the collection, or referral for collection to a single State agency, of overpayments that are made under the State health security program to providers and that are discovered by the fraud unit in carrying out its activities.

(d) RESOURCES.—The fraud unit must—

(1) employ such auditors, attorneys, investigators, and other necessary personnel,

(2) be organized in such a manner, and

(3) provide sufficient resources (as specified by the Board),

as is necessary to promote the effective and efficient conduct of the unit's activities.

(e) COOPERATIVE AGREEMENTS.—The fraud unit must have cooperative agreements (as specified by the Board) with—

(1) similar fraud units in other States,

(2) the Inspector General, and

(3) the Attorney General of the United States.

(f) REPORTS.—The fraud unit must submit to the Inspector General an application and annual reports containing such information as the Inspector General determines to be necessary to determine whether the unit meets the previous requirements of this section.

SEC. 414. ASSIGNMENT OF UNIQUE PROVIDER AND PATIENT IDENTIFIERS.

(a) PROVIDER IDENTIFIERS.—

(1) IN GENERAL.—The Board shall provide for the assignment, to each individual or entity providing health care services under a State health security program, of a unique provider identifier.

(2) RESPONSE TO QUERIES.—Upon the request of a State health security program with respect to a provider, the Board shall provide the program with the unique provider identifier (if any) assigned to the provider under paragraph (1).

(b) PATIENT IDENTIFIERS.—The Board shall provide for the assignment, to each eligible individual, of a unique patient identifier. The identifier so assigned may be the Social Security account number of the individual.

(c) REQUIREMENT TO USE IDENTIFIERS.—Each State health security program is required under section 405(b)(1)(M) to use the unique identifiers assigned under this section.

TITLE V—QUALITY ASSESSMENT

SEC. 501. FUNCTIONS OF QUALITY COUNCIL; DEVELOPMENT OF PRACTICE GUIDELINES AND APPLICATION TO OUTLIERS.

(a) DEVELOPMENT OF PRACTICE GUIDELINES.—The American Health Security Quality Council (in this title referred to as the ''Council'')—

(1) shall collect data from outcomes research (whether conducted by the Federal Government or other entities), and

(2) on the basis of such data and existing clinical knowledge, shall develop practice guidelines.

Such guidelines may vary based upon the area in which the services are provided and the degree of training, specialization, or similar characteristics of providers.

(b) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Council shall adopt meth-

odologies for profiling the patterns of practice of health care professionals and for identifying outliers (as defined in subsection (f)).

(c) CENTERS OF EXCELLENCE.—The Council shall develop guidelines for certain medical procedures designated by the Board to be performed at tertiary care centers which can meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. The Board shall develop incentives to encourage such procedures to be performed at centers that meet such standards.

(d) REMEDIAL ACTIONS.—The Council shall develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services provided under this Act.

(e) DISSEMINATION.—The Council shall disseminate to the State health security program—

(1) the guidelines developed under subsections (a) and (c),

(2) the methodologies adopted under subsection (b), and

(3) the standards developed under subsection (d),

for use by the States under section 502.

(f) OUTLIER DEFINED.—In this title, the term ''outlier'' means a health care practitioner whose pattern of practice, relative to applicable practice guidelines, suggests deficiencies in the quality of health care services being provided.

SEC. 502. STATE QUALITY REVIEW PROGRAMS.

(a) REQUIREMENT.—In order to meet the requirement of section 405(b)(1)(I), each State health security program shall establish one or more qualified entities to conduct quality reviews of persons providing covered services under the program, in accordance with standards established under subsection (b)(1) (except as provided in subsection (b)(2)) and subsection (d).

(b) FEDERAL STANDARDS.—

(1) IN GENERAL.—The Board shall establish standards with respect to—

(A) the adoption of practice guidelines (developed under section 501(a)),

(B) the identification of outliers (consistent with methodologies adopted under section 501(b)),

(C) the development of remedial programs and monitoring for outliers, and

(D) the application of sanctions (consistent with the standards developed under section 501(d)).

(2) STATE DISCRETION.—A State may apply under subsection (a) standards other than those established under paragraph (1) so long as the State demonstrates to the satisfaction of the Council on an annual basis that the standards applied have been as efficacious in promoting and achieving quality of care as the application of the standards established under paragraph (1).

(c) QUALIFICATIONS.—An entity is not qualified to conduct quality reviews under subsection (a) unless the entity—

(1) is administratively independent of the individual or board that administers the State health security program, and

(2) does not provide any financial incentive to reviewers to favor one pattern of practice over another.

SEC. 503. CERTIFICATION; UTILIZATION REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services and other services of the type

described in such sections 1814(a) and 1835(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

(b) REQUIREMENTS AND STANDARDS FOR UTILIZATION REVIEW.—

(1) USE OF UTILIZATION REVIEW PERMITTED.—A State health security program may—

(A) establish a utilization review program (as defined in paragraph (4)), and

(B) deny coverage (and payment) for services to the extent the services are determined under such a utilization review program not to meet the coverage standards specified in section 201(a),

but only if the program meets the standards established by the Board under paragraph (2).

(2) STANDARDS FOR UTILIZATION REVIEW PROGRAMS.—

(A) IN GENERAL.—The Board shall provide, by regulation, for the establishment of Federal standards for utilization review programs conducted by State health security programs. Such standards shall be designed to assure the cost-effective and medically appro-

priate use of services consistent with coverage standards specified in section 201(a).

(B) TYPES OF STANDARDS.—Such standards shall be established, consistent with subparagraph (C), with respect to at least each of the following aspects of utilization review programs:

(i) The qualification of those who may perform utilization review activities.

(ii) The standards to be applied in performing utilization review.

(iii) The timeliness in which utilization review determinations (and appeals with respect to such determinations) are to be made.

(iv) An appeals (or alternative dispute resolution) process which provides a fair opportunity for individuals adversely affected by a utilization review determination (or their families or care coordinators) to have such a determination reviewed.

(v) Protection for the confidentiality of individually-identifiable information used in the process, consistent with Federal and State laws.

(C) STANDARDS.—The standards established under this paragraph shall include the following:

(i) The individuals making final determinations (and determining appeals) concerning the utilization of services provided by members of a health profession shall be members of the same profession (or in an associated field, as determined by the Board).

(ii) The utilization criteria to be applied shall be provided to patients, providers, and care coordinators upon request and a written explanation of the basis for any denial of payment based upon such a review shall be provided to the patient, provider, or care coordinator upon request.

(iii) Utilization review and appeals shall be conducted promptly in order not to disrupt a course of treatment and providers shall not deny necessary care while a review or appeal is pending.

(iv) The system may not provide a monetary incentive for those conducting

utilization review activities to deny or reduce payment for services.

(v) The medical personnel performing reviews shall be accessible by telephone to the providers whose services they review.

(D) USE OF GUIDELINES.—Such standards shall be consistent with the provisions of section 204(d) (relating to application of national practice guidelines).

(3) NO REQUIREMENT FOR ROUTINE UTILIZATION REVIEW.—Nothing in this title shall be construed to require or authorize a State health security program to provide for utilization review as a routine practice in all cases.

(4) UTILIZATION REVIEW PROGRAM.—In this title, the term ''utilization review program'' means a system of reviewing the medical necessity and appropriateness (including the appropriateness of the setting) of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, the profiling of practice patterns, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment for services exceeding specified levels or duration be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other qualified professionals. Such a plan may include, consistent with subsection (b), utilization review at specified intervals as a further condition of payment for services.

SEC. 504. DEVELOPMENT OF NATIONAL ELECTRONIC DATA BASE.

(a) USE BY STATES.—In order to meet the requirement of this section, for purposes of section 405(b)(1)( ), each State health security program shall develop and use a uniform electronic data base which uses the software designated under subsection (b) and which assures confidentiality under subsection (c), for all patient records in order to enable systematic quality review and outcomes analysis. Subject to subsection (c), data in such data base shall be made available, under rules established by the Board, in order to facilitate the portability of patient records and comparative outcomes research analysis.

(b) UNIFORM SOFTWARE.—The Board shall designate the characteristics of the software that shall be used by States in the operation of their electronic data

bases, in order to ensure the portability of patient records and comparative outcomes research analysis. The Board shall not grant any waiver of the requirement of the previous sentence.

(c) CONFIDENTIALITY.—The Board shall establish standards that are designed to protect the privacy and otherwise shield the identity of the patients whose records are included in the data base. Under such standards, government agencies shall not have access to information in the data base that will identify individual patients except in cases of quality review procedures which require that individual patients be informed of necessary changes in their treatment.

TITLE VI—HEALTH SECURITY BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting and Payments to States

SEC. 601. AMERICAN HEALTH SECURITY BUDGET.

(a) AMERICAN HEALTH SECURITY BUDGET.—

(1) IN GENERAL.—By not later than September 1 before the beginning of each year (beginning with 1995), the Board shall establish an American health security budget, which—

(A) specifies the total expenditures (including expenditures for administrative costs) to be made by the Federal Government and the States for covered health care services under this Act, and

(B) allocates those expenditures among the States consistent with section 604.

Pursuant to subsection (b), such budget for a year shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The American health security budget shall consist of 4 components:

(A) A component for capital expenditures.

(B) A component for administrative costs.

(C) A component (in this title referred to as the ''operating component'') for operating and other expenditures not described in subparagraphs (A) through (C) consisting of amounts not included in the other components.

(3) ALLOCATION AMONG COMPONENTS.—Taking into account the State health security budgets established and submitted under section 603, the Board shall allocate the American health security

budget among the components in a manner that assures that the capital expenditure component is sufficient to meet the need for covered health care services (consistent with the national health security spending growth limit); and

(b) BASIS FOR TOTAL EXPENDITURES.—

(1) IN GENERAL.—The total expenditures specified in such budget shall be the sum of the capitation amounts computed under section 602(a) and the amount of Federal administrative expenditures needed to carry out this Act.

(2) NATIONAL HEALTH SECURITY SPENDING GROWTH LIMIT.—For purposes of this subtitle, the national health security spending growth limit described in this paragraph for a year is zero, or, if greater, the percentage increase in the gross domestic product (in current dollars) from the first quarter of the second previous year to the first quarter of the previous year.

(c) DEFINITION.—In this title the term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and includes return on equity capital.

SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPITATION AMOUNTS.

(a) CAPITATION AMOUNTS.—

(1) INDIVIDUAL CAPITATION AMOUNTS.—In establishing the American health security budget under section 601(a) and in computing the national average per capita cost under subsection (b) for each year, the Board shall establish a method for computing the capitation amount for each eligible individual residing in each State. The capitation amount for an eligible individual in a State classified within a risk group (established under subsection (d)(2)) is the product of—

(A) a national average per capita cost for all covered health care services (computed under subsection (b)),

(B) the State adjustment factor (established under subsection (c)) for the State, and

(C) the risk adjustment factor (established under subsection (d)) for the risk group.

(2) STATE CAPITATION AMOUNT.—

(A) IN GENERAL.—For purposes of this title, the term ''State capitation amount'' means, for a State for a year, the sum of the capitation amounts computed under paragraph (1) for all the residents of the State in the year,

as estimated by the Board before the beginning of the year involved.

(B) USE OF STATISTICAL MODEL.—The Board may provide for the computation of State capitation amounts based on statistical models that fairly reflect the elements that comprise the State capitation amount described in subparagraph (A).

(C) POPULATION INFORMATION.—The Bureau of the Census shall assist the Board in determining the number, place of residence, and risk group classification of eligible individuals.

(b) COMPUTATION OF NATIONAL AVERAGE PER CAPITA COST.—

(1) FOR 1995.—For 1995, the national average per capita cost under this paragraph is equal to—

(A) the average per capita health care expenditures in the United States in 1993 (as estimated by the Board),

(B) increased to 1994 by the Board's estimate of the actual amount of such per capita expenditures during 1994, and

(C) updated to 1995 by the national health security spending growth limit specified in section 601(b)(2) for 1995.

(2) FOR SUCCEEDING YEARS.—For each succeeding year, the national average per capita cost under this subsection is equal to the national average per capita cost computed under this subsection for the previous year increased by the national health security spending growth limit (specified in section 601(b)(2)) for the year involved.

(c) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Board shall develop for each State a factor to adjust the national average per capita costs to reflect differences between the State and the United States in—

(A) average labor and nonlabor costs that are necessary to provide covered health services;

(B) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d);

(C) the geographic distribution of the State's population, particularly the proportion of the population residing in medically underserved areas, to the extent such a condition is

not taken into account in the establishment of risk groups under subsection (d); and

(D) any other factor relating to operating costs required to assure equitable distribution of funds among the States.

(2) MODIFICATION OF CAPITAL EXPENDITURE COMPONENT.—With respect to the portion of the national budget allocated to capital expenditures, the Board shall modify the State adjustment factors so as to take into account differences among States in their relative need for capital expenditures among the States and the availability of tertiary care centers and centers of excellence in neighboring States, taking into account the capital expenditures proposed in State health security budgets under section 603(a).

(3) BUDGET NEUTRALITY.—The State adjustment factors, as modified under paragraph (2), shall be applied under this subsection in a manner that results in neither an increase nor a decrease in the total amount of the Federal contributions to all State health security programs under subsection (b) as a result of the application of such factors.

(4) PHASE-IN.—In applying State adjustment factors under this subsection during the five-year pe-

riod beginning with 1995, the Board shall phase-in, over such period, the use of factors described in paragraph (1) in a manner so that the adjustment factor for a State is based on a blend of such factors and a factor that reflects the relative actual average per capita costs of health services of the different States as of the time of enactment of this Act.

(5) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the State adjustment factors under this subsection.

(d) ADJUSTMENTS FOR RISK GROUP CLASSIFICATION.—

(1) IN GENERAL.—The Board shall develop an adjustment factor to the national average per capita costs computed under subsection (b) for individuals classified in each risk group (as designated under paragraph (2)) to reflect the difference between the average national average per capita costs and the national average per capita cost for individuals classified in the risk group.

(2) RISK GROUPS.—The Board shall designate a series of risk groups, determined by age, health in-

dicators, and other factors that represent distinct patterns of health care services utilization and costs.

(3) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the risk adjustment factors under this subsection.

SEC. 603. STATE HEALTH SECURITY BUDGETS.

(a) ESTABLISHMENT AND SUBMISSION OF BUDGETS.—

(1) IN GENERAL.—Each State health security program shall establish and submit to the Board for each year a proposed and a final State health security budget, which specifies the following:

(A) The total expenditures (including expenditures for administrative costs) to be made under the program in the State for covered health care services under this Act, consistent with subsection (b), broken down as follows:

(i) By the 3 components (described in section 601(a)(2)), consistent with subsection (b).

(ii) Within the operating component—

(I) expenditures for operating costs of hospitals, nursing facilities,

and other facility-based services in the State,

(II) expenditures for payment to comprehensive health service organizations,

(III) expenditures for payment of services provided by health care practitioners, and

(IV) expenditures for other covered items and services.

(B) The total revenues required to meet the State health security expenditures.

(2) PROPOSED BUDGET DEADLINE.—The proposed budget for a year shall be submitted under paragraph (1) not later than June 1 before the year.

(3) FINAL BUDGET.—The final budget for a year shall—

(A) be established and submitted under paragraph (1) not later than October 1 before the year, and

(B) take into account the amounts established under the national health security budget under section 601 for the year.

(4) ADJUSTMENT IN ALLOCATIONS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a final budget, a State may change the allocation of amounts among components.

(B) NOTICE.—No such change may be made unless the State has provided prior notice of the change to the Board.

(C) DENIAL.—Such a change may not be made if the Board, within such time period as the Board specifies, disapproves such change.

(b) EXPENDITURE LIMITS.—

(1) IN GENERAL.—The total expenditures specified in each State health security budget under subsection (a)(1) shall take into account Federal contributions made under section 604.

(2) LIMIT ON CLAIMS PROCESSING AND BILLING EXPENDITURES.—Each State health security budget shall provide that State administrative expenditures, including expenditures for claims processing and billing, shall not exceed 3 percent of the total expenditures under the State health security program, unless the Board determines, on a case-by-case basis, that additional administrative expenditures would improve health care quality and cost effectiveness.

(3) WORKER ASSISTANCE.—A State health security program may provide that, for budgets for years before 2000, up to 1 percent of the budget may be used for purposes of programs providing assistance to workers who are currently performing functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of the program.

SEC. 604. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State health security program is entitled to receive, from amounts in the American Health Security Trust Fund, on a monthly basis each year, of an amount equal to one-twelfth of the product of—

(1) the State capitation amount (computed under section 602(a)(2)) for the State for the year, and

(2) the Federal contribution percentage (established under subsection (b)).

(b) FEDERAL CONTRIBUTION PERCENTAGE.—The Board shall establish a formula for the establishment of a Federal contribution percentage for each State. Such formula shall take into consideration a State's per capita income and revenue capacity and such other relevant eco-

nomic indicators as the Board determines to be appropriate. In addition, during the 5-year period beginning with 1995, the Board may provide for a transition adjustment to the formula in order to take into account current expenditures by the State (and local governments thereof) for health services covered under the State health security program. The weighted-average Federal contribution percentage for all States shall equal 86 percent and in no event shall such percentage be less than 81 percent nor more than 91 percent.

(c) USE OF PAYMENTS.—All payments made under this section may only be used to carry out the State health security program.

(d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

(1) SPENDING EXCESS.—If a State exceeds its budget in a given year, the State shall continue to fund covered health services from its own revenues.

(2) SURPLUS.—If a State provides all covered health services for less than the budgeted amount for a year, it may retain its Federal payment for that year for uses consistent with this Act.

SEC. 605. REQUIRED APPROVAL PROCESS FOR CAPITAL EXPENDITURES.

(a) PROCESS.—

(1) IN GENERAL.—Consistent with standards established under subsection (b), each State health security program shall provide for a process for the approval of capital expenditures (as defined in subsection (c)) in order—

(A) to meet the need for covered health care services consistent with State budgets and the development of medical technology,

(B) to establish an efficient balance between the need for services and the delivery of services, and

(C) to expand the delivery of services in medically underserved areas.

(2) CONDITIONS FOR APPROVAL.—No expenditures (including operating costs, rent, depreciation, and interest) may be approved by a State health security program to the extent they are attributable to a capital expenditure which was subject to, but was not approved under, such process.

(b) STANDARDS FOR CAPITAL APPROVAL PROCESS.—

(1) IN GENERAL.—The Board shall specify standards for the process, to be implemented under each State health security program, for the approval of capital expenditures.

(2) REQUIREMENTS.—Under such standards, such process—

(A) if there is a limit on capital expenditures, shall assure that such expenditures are distributed geographically within a State taking into account at least the factors described in paragraph (3);

(B) shall assure that health care providers and consumers are provided reasonable opportunities for involvement in the process;

(C) may provide for such special consideration as the Board specifies in the case of institutions of national repute or other institutions disproportionately serving interstate populations;

(D) may provide for the special consideration of religious and charitable organizations that have raised voluntary contributions for such capital expenditures;

(E) may provide for such priorities for comprehensive health service organizations as the Board specifies; and

(F) may provide for limits on the distribution among different types of facilities or capital projects as the Board may find necessary in

order to prevent significant maldistributions while retaining the maximum flexibility of States to provide for covered health services in each State.

(3) FACTORS.—The factors to be taken into account under this paragraph in the distribution of capital expenditures are as follows:

(A) The population of the different geographic areas within the State, its dispersion, and the risk characteristics (measured by health indicators), based on the risk factors described in section 603(d).

(B) The capital needs of the different geographic areas of the State in order to ensure adequate access to general and specialty services and technologies and to ensure medical effectiveness.

(C) The need to correct for historical maldistribution in the allocation of health care capital that preceded the enactment of this Act.

(c) CAPITAL EXPENDITURES DEFINED.—

(1) IN GENERAL.—In this Act, the term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment valued at at least an amount

(specified by the Board) or of a kind specified by the Board.

(2) INCLUSION OF ADDITIONAL EXPENDITURES.—A State health security program may require approval of capital expenditures not described in paragraph (1).

Subtitle B—Payments by States to Providers

SEC. 611. PAYMENTS TO HOSPITALS AND NURSING FACILITY SERVICES FOR OPERATING EXPENSES ON THE BASIS OF APPROVED GLOBAL BUDGETS.

(a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—Payment for operating expenses for hospital services and nursing facility services under State health security programs shall be made directly to each hospital or nursing facility by each State health security program under an annual prospective global budget approved under the program. Such a budget shall include payment for outpatient care and non-facility-based care that is furnished by or through the facility. In the case of a hospital that is wholly owned (or controlled) by a comprehensive health service organization that is paid under section 614 on the basis of a global budget, the global budget of the organization shall include the budget for the hospital.

(b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

(1) IN GENERAL.—The prospective global budget for a hospital or nursing facility shall be developed through annual negotiations between the State health security program and the hospital or nursing facility and be based on a nationally uniform system of cost accounting established under standards of the Board.

(2) CONSIDERATIONS.—In developing a budget through negotiations, there shall be taken into account at least the following:

(A) With respect to inpatient hospital services, the number, and classification by diagnosis-related group, of discharges.

(B) A hospital's or nursing facility's past expenditures.

(C) Change in the consumer price index and other price indices.

(D) The cost of reasonable compensation to health care practitioners.

(E) The compensation level of the hospital's or nursing facility's workforce.

(F) The extent to which the hospital or nursing facility is providing health care services to meet the needs of residents in the area served by the hospital or nursing facility, in-

cluding the hospital's or nursing facility's occupancy level.

(G) The hospital's or nursing facility's previous financial and clinical performance, based on utilization and outcomes data provided under this Act.

(H) The type of hospital or nursing facility, including whether the hospital or nursing facility is part of a clinical education program or serves a health professional education, research or other training purpose.

(I) Technological advances or changes.

(J) Costs of the hospital or nursing facility associated with meeting Federal and State regulations.

(K) The costs associated with necessary public outreach activities.

(L) In the case of a for-profit hospital or nursing facility, a reasonable rate of return on equity capital, independent of those operating expenses necessary to fulfill the objectives of this Act, reduced (consistent with subparagraph (M)) by any operating profit.

(M) Incentives to facilities that maintain costs below previous reasonable budgeted levels without reducing the care provided.

(N) With respect to hospitals or nursing facilities that provide mental health services and substance abuse treatment services, any additional costs involved in the treatment of dually diagnosed individuals.

(3) APPROVAL REQUIRED OF CAPITAL EXPENDITURES.—No expenditures may be approved as part of a budget of a hospital or nursing facility under this section to the extent they are attributable to an expenditure for a capital expenditure that was subject to, but was not approved under, the process described in section 605.

(4) REVIEW BY ADVISORY COUNCILS.—A State shall not approve a budget of a hospital or nursing facility unless, prior to such approval, the State Health Security Advisory Council and the appropriate district health advisory council have had an opportunity to review and submit any comments concerning the budget.

(5) PROVISION OF REQUIRED INFORMATION; DIAGNOSIS-RELATED GROUP.—No budget for a hospital or nursing facility for a year may be approved

unless the hospital or nursing facility has submitted on a timely basis to the State health security program such information as the program or the Board shall specify, including in the case of hospitals information on discharges classified by diagnosis-related group.

(c) ADJUSTMENTS IN APPROVED BUDGETS.—

(1) ADJUSTMENTS TO GLOBAL BUDGETS THAT CONTRACT WITH COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.—Each State health security program shall develop an administrative mechanism for reducing operating funds to hospitals or nursing facilities in proportion to payments made to such hospitals or nursing facilities for services contracted for by a comprehensive health service organization.

(2) AMENDMENTS.—In accordance with standards established by the Board, an operating and capital budget approved under this section for a year may be amended before, during, or after the year if there is a substantial change in any of the factors relevant to budget approval.

(d) DONATIONS PERMISSIBLE.—The Board shall promulgate regulations permitting hospitals and nursing facilities to raise funds from private sources to pay for newly constructed facilities, major renovations, and equip-

ment. The expenditure of such funds, whether for operating or capital expenditures, does not obligate the State health security program to provide for continued support for such expenditures unless included in an approved global budget and, in the case of capital expenditures, unless approved under the process described in section 605.

SEC. 612. PAYMENTS FOR OTHER FACILITY-BASED SERVICES.

(a) IN GENERAL.—Payments under a State health security program for home health services, hospice care, home and community-based long-term care services, and facility-based outpatient services (other than those described in section 611) shall be based on—

(1) a global budget (described in section 611),

(2) a capitation amount (described in subsection (c)),

(3) a fee schedule under section 613, or

(4) an alternative prospective payment method that is approved by the State health security program.

Such payments shall not include payments for capital expenditures, except as provided in subsection (b).

(b) CONSIDERATION IN ESTABLISHMENT OF CAPITATION AMOUNTS.—A capitation amount, fee schedule, or

alternative prospective payment method established under subsection (a) for facility-based services shall—

(1) take into account the payment amounts established under section 613 for any related professional services, and

(2) be consistent with section 605(a)(2).

(c) CAPITATION AMOUNT.—

(1) IN GENERAL.—The capitation amount described in this subsection for an enrollee with a provider of services described in subsection (a), with respect to such services, shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for such an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall ad-

just such average amounts to take into account the cost of services covered by such enrollment that are not provided by the provider.

SEC. 613. PAYMENTS TO HEALTH CARE PRACTITIONERS BASED ON PROSPECTIVE FEE SCHEDULE.

(a) FEE FOR SERVICE.—

(1) IN GENERAL.—Every independent health care practitioner is entitled to be paid, for the provision of covered health services under the State health security program, a fee for each billable covered service.

(2) GLOBAL FEE PAYMENT METHODOLOGIES.—The Board shall establish models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services (such as all outpatient procedures for treatment of a condition) or for a basic group of services (such as primary care services) furnished to an individual over a period of time, in order to encourage continuity and efficiency in the provision of services. Such methodologies shall be designed to ensure a high quality of care.

(3) BILLING DEADLINES; ELECTRONIC BILLING.—A State health security program may deny payment for any service of an independent health

care practitioner for which it did not receive a bill and appropriate supporting documentation (which had been previously specified) within 30 days after the date the service was provided. Such a program may require that bills for services for which payment may be made under this section, or for any class of such services, be submitted electronically.

(4) DENIAL OF PAYMENT FOR CERTAIN SERVICES.—Payment shall not be made under a State health security program for any service attributable to a capital expenditure subject to approval under section 605 which has not been approved under that section. A practitioner may not impose a charge for a service for which payment is denied under the previous sentence.

(b) PAYMENT RATES BASED ON PROSPECTIVE FEE SCHEDULES.—

(1) IN GENERAL.—With respect to any payment method for a class of services of practitioners, the State health security program shall establish, on a prospective basis, a payment schedule. The State health security program shall establish such a schedule only after negotiations with organizations representing the practitioners involved. Such a fee schedule shall be designed to provide incentives for

practitioners to choose primary care medicine, including general internal medicine and pediatrics, over medical specialization.

(2) FEE FOR SERVICE SCHEDULES BASED ON NATIONAL RELATIVE VALUE SCALE.—The amount under the fee schedule shall—

(A) be based on a relative value scale, developed by the State consistent with the standards established under section 1848 of the Social Security Act, as in effect on the day before the date of the enactment of this Act, including such updates and modifications as the Board may undertake;

(B) be based on conversion factors established by each State consistent with the State health security budget;

(C) provide for the application of volume performance standards, in accordance with standards established by the Board, based on class of service (specified under paragraph (3)) and geographic area (as specified under the State health security program); and

(D) provide, based on such class and area, for quarterly adjustments in present or future payment rates depending on whether expendi-

tures are below or above such performance standards.

In applying volume performance standards under subparagraphs (C) and (D), State health security programs may provide for adjustment of rates on a practitioner-specific basis to reflect utilization patterns of individual practitioners and may publicly disclose such utilization patterns for individual practitioners (but only in a manner that does not identify individual patients).

(3) CLASS OF SERVICES.—In paragraph (2), each of the following shall be considered to be a separate class of services:

(A) Mental health services.

(B) Substance abuse treatment services.

(C) Dental services.

(D) Home and community-based long-term care services.

(E) Other practitioner services (or such classes of such services as a State may establish).

(c) BILLABLE COVERED SERVICE DEFINED.—In this section, the term ''billable covered service'' means a service covered under section 201 for which a practitioner is enti-

tled to compensation by payment of a fee determined under this section.

SEC. 614. PAYMENTS TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—Payment under a State health security program to a comprehensive health service organization to its enrollees shall be determined by the State—

(1) based on a global budget described in section 611, or

(2) subject to subsection (c), based on the basic capitation amount described in subsection (b) for each of its enrollees plus an amount equal to the amount of capital expenditures that have been approved under section 605.

In applying paragraph (1), any reference in section 611 to a hospital shall be deemed a reference to a comprehensive health service organization.

(b) BASIC CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic capitation amount described in this subsection for an enrollee shall be determined by the State health security program on the basis of the average amount of expenditures (not including expenditures attributable to capital expenditures) that is estimated would be made under the State health security program for covered health

care services for an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the organization.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of covered health care services that are not provided by the comprehensive health service organization under section 303(a).

(c) SPECIAL RULE FOR FOR-PROFIT ORGANIZATIONS.—In the case of a for-profit comprehensive health service organization, the total amount of capitation payments under subsection (a)(2) in a period shall be reduced by operating profit for the period less a reasonable rate of return on equity capital and such profit shall be additionally limited to such amounts as the Board determines are attributable to operating efficiencies and not to any reduction of care provided.

SEC. 615. PAYMENTS FOR COMMUNITY-BASED PRIMARY HEALTH FACILITIES.

(a) IN GENERAL.—In the case of community-based primary health facilities, subject to subsection (b), payments under a State health security program shall be based on—

(1) a global budget described in section 611,

(2) the basic primary care capitation amount described in subsection (c) for each individual enrolled with the provider of such services,

(3) a fee schedule under section 613, or

(4) an alternative prospective payment method that is approved by the State health security program.

(b) PAYMENT ADJUSTMENT.—Payments under subsection (a) may include, consistent with the budgets developed under this title—

(1) an additional amount, as set by the Board, to cover the costs incurred by a provider which serves persons not covered by this Act whose health care is essential to overall community health and the control of communicable disease, and for whom the cost of such care is otherwise uncompensated,

(2) an additional amount, as set by the Board, to cover the reasonable costs incurred by a provider that furnishes case management services (as defined

in section 1915(g)(2) of the Social Security Act), transportation services, and translation services, and

(3) an additional amount, as set by the Board, to cover the costs incurred by a provider in conducting health professional education programs in connection with the provision of such services.

(c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic primary care capitation amount described in this subsection for an enrollee with a provider of community-based primary health services shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for such an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the

cost of community-based primary health services that are not provided by the provider.

(d) COMMUNITY-BASED PRIMARY HEALTH SERVICES DEFINED.—In this section, the term ''community-based primary health services'' has the meaning given such term in section 202(a).

SEC. 616. PAYMENTS FOR PRESCRIPTION DRUGS.

(a) ESTABLISHMENT OF CLASSIFICATION.—

(1) IN GENERAL.—Based upon the recommendations of the Advisory Committee on Prescription Drugs under section 403(f), the Board shall establish classifications of prescription drugs and biologicals that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this Act.

(2) EXCLUSIONS.—The Board may exclude reimbursement under this Act for ineffective, unsafe, or over-priced products where better alternatives are determined to be available.

(b) PRICES.—For each such classified prescription drug or biological covered under this Act, for insulin, and for medical foods, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this Act as the cost of

a drug to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with product manufacturers and distributors in determining the applicable product price or prices.

(c) CHARGES BY INDEPENDENT PHARMACIES.—Each State health security program shall provide for payment for a prescription drug or biological or insulin furnished by an independent pharmacy based on the drug's cost to the pharmacy (not in excess of the applicable product price established under subsection (b)) plus a dispensing fee. In accordance with standards established by the Board, each State health security program, after consultation with representatives of the pharmaceutical profession, shall establish schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of prescription drugs dispensed, differences in services provided, the need to maintain expenditures within the budgets established under this title, and other relevant factors.

SEC. 617. PAYMENTS FOR APPROVED DEVICES AND EQUIPMENT.

(a) ESTABLISHMENT OF LIST.—The Board shall establish a list of approved durable medical equipment and

therapeutic devices and equipment (including eyeglasses, hearing aids, and prosthetic appliances), that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this Act.

(b) CONSIDERATIONS AND CONDITIONS.—In establishing the list under subsection (a), the Board shall take into consideration the efficacy, safety, and cost of each item contained on such list, and shall attach to any item such conditions as the Board determines appropriate with respect to the circumstances under which, or the frequency with which, the item may be prescribed.

(c) PRICES.—For each such listed item covered under this Act, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this Act as the cost of the item to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with equipment and device manufacturers and distributors in determining the applicable product price or prices.

(d) EXCLUSIONS.—The Board may exclude from coverage under this Act ineffective, unsafe, or overpriced products where better alternatives are determined to be available.

SEC. 618. PAYMENTS FOR OTHER ITEMS AND SERVICES.

In the case of payment for other covered health services, the amount of payment under a State health security program shall be established by the program—

(1) in accordance with payment methodologies which are specified by the Board after consultation with the American Health Security Advisory Council and the Board's standing Advisory Committee on Cost Containment, and

(2) consistent with the State health security budget.

SEC. 619. ROLE OF COMMISSIONS IN ESTABLISHING PAYMENT RATES.

(a) ROLE OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.—The Prospective Payment Assessment Commission, instead of conducting activities described in section 1886 of the Social Security Act, shall advise the Board concerning the approval of prospective global budgets for hospitals and nursing facilities under section 611 and shall annually prepare and submit to the Congress and the Board a report containing the recommendations of the Commission concerning the most appropriate manner in which the budget approval process should be modified to best meet the objectives of this title.

(b) ROLE OF THE PRACTITIONER PAYMENT REVIEW COMMISSION.—

(1) REDESIGNATION.—The Commission established under section 1845 of the Social Security Act is renamed the ''Practitioner Payment Review Commission'' (hereafter referred to in this subsection as the ''Commission'') and is continued for purposes of carrying out this subsection.

(2) ADDITIONAL MEMBERS.—The Director of the Congressional Office of Technology Assessment shall increase the membership of the Commission to such number as may be necessary to include the representation of nurses and other health care professionals whose services are paid for on the basis of a relative-value fee schedule established under section 613, and shall consult with the General Health Care Payment Review Commission and other appropriate provider organizations.

(3) ALTERNATIVE FUNCTIONS.—The Commission, instead of conducting activities of the type described in section 1845 of the Social Security Act, shall advise the Board concerning the fee schedules established under section 613 and shall annually prepare and submit to Congress and the Board a report containing recommendations concerning the manner in which payment schedules under sub-

section (b) of such section should be modified to best meet the objectives of this title.

(c) GENERAL HEALTH CARE PAYMENT REVIEW COMMISSION.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Director of the Congressional Office of Technology Assessment shall provide for the appointment of a General Health Care Payment Review Commission (hereafter referred to in this subsection as the ''Commission''), to be composed of individuals with national recognition for their expertise in health care economics and related fields for items and services for which payment is made under section 616, 617, 618, or 620(a), representatives of providers and manufacturers of such items and services, and representatives of consumers of these items and services.

(B) APPOINTMENTS.—Members of the Commission shall first be appointed not later than January 1, 1994, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than one-third of the number of members expire in

any year. Appointments shall be made without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(C) MEMBERSHIP.—Membership on the Commission shall include health care economists, representatives of providers and manufacturers of such items and services, and representatives of consumers of these items and services.

(2) FUNCTIONS.—The Commission shall advise the Board concerning the payment amounts established under sections 616, 617, 618, and 620(a) and shall annually prepare and submit to Congress and the Board a report containing recommendations on the manner in which such payment amounts should be modified to best meet the objectives of this title.

(d) LONG-TERM CARE PAYMENT REVIEW COMMISSION—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Director of the Congressional Office of Technology Assessment shall provide for the appointment of a Long-Term Care Payment Review Commission (hereafter referred to in this subsection as the

''Commission'') to be composed of individuals with national recognition for their expertise in health care economics and related fields for nursing facility services, home health services, hospice care, and home and community-based long-term care services.

(B) APPOINTMENTS.—Members of the Commission shall first be appointed not later than January 1, 1994, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than one-third of the number of members expire in any year. Appointments shall be made without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(C) MEMBERSHIP.—Members of the Commission shall include health care economists, representatives of providers and manufacturers of such services, and consumers of such services.

(2) FUNCTIONS.—The Commission shall advise the Board concerning the payment amounts for long-term care established under this subtitle and

shall annually prepare and submit to Congress and the Board an annual report containing the recommendations of the Commission concerning the manner in which global budgets and payment methodologies should be modified to best meet the objectives of this title.

SEC. 620. PAYMENT INCENTIVES FOR MEDICALLY UNDERSERVED AREAS.

(a) MODEL PAYMENT METHODOLOGIES.—In addition to the payment amounts otherwise provided in this title, the Board shall establish model payment methodologies and other incentives that promote the provision of covered health care services in medically underserved areas, particularly in rural and inner-city underserved areas.

(b) CONSTRUCTION.—Nothing in this title shall be construed as limiting the authority of State health security programs to increase payment amounts or otherwise provide additional incentives, consistent with the State health security budget, to encourage the provision of medically necessary and appropriate services in underserved areas.

SEC. 621. WAIVER AUTHORITY FOR ALTERNATIVE PAYMENT METHODOLOGIES.

(a) IN GENERAL.—Upon application of a State health security program as part of its plan under section

405(a), the Board may waive a required payment methodology under this subtitle as it may be necessary to allow alternative payment methodologies or to conduct experiments and demonstration projects, consistent with the State health security budget.

(b) CONDITIONS FOR APPROVAL.—The Board may not approve a request for such a waiver unless the Board determines that such payment methodology does not adversely affect the entitlement of individuals to coverage, the benefits covered under the program, the quality of services provided under the program, the ability of individuals to choose among qualified providers, the weighting of fee schedules to encourage an increase in the number of primary care practitioners, or the compliance of the program with the State health security budget under subtitle A.

(c) PERIODIC REPORTS.—The continued approval of such a waiver is conditioned upon the program submitting periodic reports to the Board showing the operation and effectiveness of the alternative methodology, in order for the Board to evaluate the appropriateness of the alternative methodology.

Subtitle C—Mandatory Assignment and Administrative Provisions

SEC. 631. MANDATORY ASSIGNMENT.

(a) NO BALANCE BILLING.—Payments for benefits under this Act shall constitute payment in full for such benefits and the entity furnishing an item or service for which payment is made under this Act shall accept such payment as payment in full for the item or service and may not accept any payment or impose any charge for any such item or service other than accepting payment from the State health security program in accordance with this Act.

(b) ENFORCEMENT.—If an entity knowingly and willfully bills for an item or service or accepts payment in violation of subsection (a), the Board may apply sanctions against the entity in the same manner as sanctions could have been imposed under section 1842(j)(2) of the Social Security Act for a violation of section 1842(j)(1) of such Act. Such sanctions are in addition to any sanctions that a State may impose under its State health security program.

SEC. 632. PROCEDURES FOR REIMBURSEMENT; APPEALS.

(a) PROCEDURES FOR REIMBURSEMENT.—In accordance with standards issued by the Board, a State health security program shall establish a timely and administra-

tively simple procedure to assure payment within 60 days of the date of submission of clean claims by providers under this Act.

(b) APPEALS PROCESS.—Each State health security program shall establish an appeals process to handle all grievances pertaining to payment to providers under this title.

TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

Subtitle A—Promotion and Expansion of Primary Care Professional Training

SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY CARE PROFESSIONAL OUTPUT GOALS.

(a) IN GENERAL.—The Board is responsible for—

(1) coordinating health professional education policies and goals, in consultation with the Secretary of Health and Human Services (in this title referred to as the ''Secretary''), to achieve the national goals specified in subsection (b);

(2) developing and maintaining, in cooperation with the Secretary, a system to monitor the number and specialties of individuals through their health professional education, any postgraduate training, and professional practice; and

(3) developing, coordinating, and promoting other policies that expand the number of primary care practitioners.

(b) NATIONAL GOALS.—The national goals specified in this subsection are as follows:

(1) GRADUATE MEDICAL EDUCATION.—By not later than 5 years after the date of the enactment of this Act, at least 50 percent of the residents in medical residency education programs (as defined in subsection (e)(1)) are primary care residents (as defined in subsection (e)(2)).

(2) MIDLEVEL PRIMARY CARE PRACTITIONERS.—To assure an adequate supply of primary care pratitioners, there shall be a number, specified by the Board, of midlevel primary care practitioners (as defined in subsection (e)(3)) employed in the health care system as of January 1, 2000.

(c) METHOD FOR ATTAINMENT OF NATIONAL GOAL FOR GRADUATE MEDICAL EDUCATION; PROGRAM GOALS.—

(1) IN GENERAL.—The Board shall establish a method of applying the national goal in subsection (b)(1) to program goals for each medical residency education program or to medical residency education consortia.

(2) CONSIDERATION.—The program goals under paragraph (1) shall be based on the distribution of medical schools and other teaching facilities within each State health security program, and the number of positions for graduate medical education.

(3) MEDICAL RESIDENCY EDUCATION CONSORTIUM.—In this subsection, the term ''medical residency education consortium'' means a consortium of medical residency education programs in a contiguous geographic area (which may be an interstate area) if the consortium—

(A) includes at least one medical school with a teaching hospital and related teaching settings, and

(B) has an affiliation with qualified community-based primary health service providers described in section 202(a) and with at least one comprehensive health service organization established under section 303.

(4) ENFORCEMENT THROUGH STATE HEALTH SECURITY BUDGETS.—The Board shall develop a formula for reducing payments to State health security programs (that provide for payments to a medical residency education program) that failed to meet the goal for the program established under this subsection.

(d) METHOD FOR ATTAINMENT OF NATIONAL GOAL FOR MIDLEVEL PRIMARY CARE PRACTITIONERS.—To assist in attaining the national goal identified in subsection (b)(2), the Board shall—

(1) advise the Public Health Service on allocations of funding under titles VII and VIII of the Public Health Service Act, the National Health Service Corps, and other programs in order to increase the supply of midlevel primary care practitioners, and

(2) commission a study of the potential benefits and disadvantages of expanding the scope of practice authorized under State laws for any class of midlevel primary care practitioners.

(e) DEFINITIONS.—In this title:

(1) MEDICAL RESIDENCY EDUCATION PROGRAM.—The term ''medical residency education program'' means a program that provides education

and training to graduates of medical schools in order to meet requirements for licensing and certification as a physician, and includes the medical school supervising the program and includes the hospital or other facility in which the program is operated.

(2) PRIMARY CARE RESIDENT.—The term ''primary care resident'' means (in accordance with criteria established by the Board) a resident being trained in a distinct program of family practice medicine, general practice, general internal medicine, or general pediatrics.

(3) MIDLEVEL PRIMARY CARE PRACTITIONER.—The term ''midlevel primary care practitioner'' means a clinical nurse practitioner, certified nurse midwife, physician assistant, or other non-physician practitioner, specified by the Board, as authorized to practice under State law.

SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON HEALTH PROFESSIONAL EDUCATION.

(a) IN GENERAL.—The Board shall provide for an Advisory Committee on Health Professional Education (in this section referred to as the ''Committee'') to advise the Board on its activities under section 701.

(b) MEMBERSHIP.—The Committee shall be composed of—

(1) the Chair of the Board, who shall serve as Chair of the Committee, and

(2) 12 members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall provide a balanced point of view with respect to health professional education, primary care disciplines, and health care policy and shall include individuals who are representative of medical schools, other health professional schools, residency programs, primary care practitioners, teaching hospitals, professional associations, public health organizations, State health security programs, and consumers.

(c) TERMS OF MEMBERS.—Each appointed member shall hold office for a term of five years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, two at the end of the second year, two at the end of the third year, two at the end of

the fourth year, and three at the end of the fifth year after the date of enactment of this Act.

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Committee in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Committee.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may reappoint an appointed member of the Committee for a second term in the same manner as the original appointment.

(e) DUTIES.—It shall be the duty of the Committee to advise the Board concerning graduate medical education policies under this title.

(f) STAFF.—The Committee, its members, and any committees of the Committee shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(g) MEETINGS.—The Committee shall meet as frequently as the Board deems necessary, but not less than 4 times each year. Upon request by four or more members it shall be the duty of the Chair to call a meeting of the Committee.

(h) COMPENSATION.—Members of the Committee shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(i) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Committee.

SEC. 703. GRANTS FOR HEALTH PROFESSIONS EDUCATION, NURSE EDUCATION, AND THE NATIONAL HEALTH SERVICE CORPS.

(a) TRANSFERS TO PUBLIC HEALTH SERVICE.—From the amounts provided under subsection (c), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service under subpart II of part D of title III, title VII, and title VIII of the Public Health Service Act for the support of the National Health Service Corps, health professions education, and nursing education, including education of clinical nurse practitioners, certified registered nurse anesthetists,

certified nurse midwives, and physician assistants. Of the amounts so transferred in each year, not less than 50 percent shall be expended for the support of the National Health Service Corps.

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 4/100 percent and not to exceed 6/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available under the provisions referred to in subsection (a) and shall be administered in accordance with the terms of such provisions. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for the programs authorized by such provisions are less than the total amount appropriated for such programs in fiscal year 1993.

Subtitle B—Direct Health Care Delivery

SEC. 711. SETASIDE FOR PUBLIC HEALTH BLOCK GRANTS.

(a) TRANSFERS TO PUBLIC HEALTH SERVICE.—From the amounts provided under subsection (c), the

Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the following purposes:

(1) For payments to States under the maternal and child health block grants under title V of the Social Security Act.

(2) Preventive health block grants under part A of title XIX of the Public Health Service Act.

(3) Grants to States for community mental health services under subpart I of part B of title XIX of the Public Health Service Act.

(4) Grants to States for prevention and treatment of substance abuse under subpart II of part B of title XIX of the Public Health Service Act.

(5) Grants for HIV health care services under parts A, B, and C of title XXVI of the Public Health Service Act.

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 1/10 percent and not to exceed 14/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision

of services are in addition to, and not in replacement of, funds made available under the programs referred to in subsection (a) and shall be administered in accordance with the terms of such programs. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for such programs are less than the total amount appropriated for such programs in fiscal year 1993.

SEC. 712. SETASIDE FOR PRIMARY HEALTH CARE DELIVERY.

(a) TRANSFERS TO PUBLIC HEALTH SERVICE.—From the amounts provided under subsection (c), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the program of primary care service expansion grants under subpart V of part D of title III of the Public Health Service Act (as added by section 713 of this Act).

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 6/100 percent and not to exceed 1/10 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision

of services are in addition to, and not in replacement of, funds made available under the sections 329, 330, 340, 340A, 1001, and 2655 of the Public Health Service Act. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for such sections are less than the total amount appropriated under such sections in fiscal year 1993.

SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end thereof the following new subpart:

"Subpart V—Primary Care Expansion

"SEC. 340D. EXPANDING PRIMARY CARE DELIVERY CAPACITY IN URBAN AND RURAL AREAS.

''(a) GRANTS FOR PRIMARY CARE CENTERS.—From the amounts described in subsection (c), the American Health Security Standards Board shall make grants to public and nonprofit private entities for projects to plan, develop, and operate primary care centers which will serve medically underserved populations (as defined in section 330(b)(3)) in urban and rural areas and to deliver primary care services to such populations in such areas. The funds provided under such a grant may be used for the same purposes for which a grant may be made under subsection (c) or (d) of section 330.

''(b) PROCESS OF AWARDING GRANTS.—The provisions of subsection (e)(1) of section 330 shall apply to a grant under this section in the same manner as they apply to a grant under subsection (c) of such section. The provisions of subsection (g)(3) of such section shall apply to grants for projects to plan and develop primary care centers under this section in the same manner as they apply to grants under such section.

''(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—Funding to carry out this section is provided from the American Health Security Trust Fund in accordance with section 712 of the American Health Security Act.

''(d) PRIMARY CARE CENTER DEFINED.—In this section, the term 'primary care center' means—

''(1) a migrant health center (as defined in section 329(a)(1)),

''(2) a community health center (as defined in section 330(a)),

''(3) an entity qualified to receive a grant under section 340, 340A, 1001, or 2655, or

''(4) a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act).''.

Subtitle C—Primary Care and Outcomes Research

SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.

(a) GRANTS FOR OUTCOMES RESEARCH.—From the amounts provided under subsection (c), the Board shall make transfers from the Trust Fund to the Agency for Health Care Policy and Research under title IX of the Public Health Service Act for the purpose of carrying out activities under such title.

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 1/100 percent and not to exceed 2/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available to the Agency for Health Care Policy and Research under section 926 of the Public Health Service Act. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations under such section are less than the total amount appropriated under such section and title in fiscal year 1993.

(d) CONFORMING AMENDMENT.—Section 926(a) of the Public Health Service Act (42 U.S.C. 299c–5(a)) is amended by striking ''$35,000,000'' and all that follows through the end and inserting ''for each fiscal year (beginning with fiscal year 1994) such sums as may be necessary.''.

SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RESEARCH.

(a) IN GENERAL.—Title IV of the Public Health Service Act, as amended by section 2 of Public Law 101–613, is amended—

(1) by redesignating section 486 as section 485A;

(2) by redesignating parts F through H as parts G through I, respectively; and

(3) by inserting after part E the following new part:

''PART F—RESEARCH ON PRIMARY CARE AND PREVENTION

''SEC. 486. OFFICE OF PRIMARY CARE AND PREVENTION RESEARCH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of Primary Care and Prevention Research (in this part referred to as the 'Office'). The Office shall

be headed by a director, who shall be appointed by the Director of NIH.

''(b) PURPOSE.—The Director of the Office shall—

''(1) identify projects of research on primary care and prevention that should be conducted or supported by the national research institutes, with particular emphasis on—

''(A) clinical patient care,

''(B) diagnostic effectiveness,

''(C) primary care education,

''(D) health and family planning services,

''(E) medical effectiveness outcomes of primary care procedures and interventions, including effects on populations within the community, district, State, or the United States, and

''(F) the use of multidisciplinary teams of health care practitioners;

''(2) identify multidisciplinary research related to primary care and prevention that should be so conducted;

''(3) promote coordination and collaboration among entities conducting research identified under any of paragraphs (1) and (2);

''(4) encourage the conduct of such research by entities receiving funds from the national research institutes;

''(5) recommend an agenda for conducting and supporting such research;

''(6) promote the sufficient allocation of the resources of the national research institutes for conducting and supporting such research; and

''(7) prepare the report required in section 486B.

''(c) COORDINATING COMMITTEE.—

''(1) In carrying out subsection (b), the Director of the Office shall establish a committee to be known as the Coordinating Committee on Research on Primary Care and Prevention Research (in this subsection referred to as the 'Coordinating Committee').

''(2) The Coordinating Committee shall be composed of the Directors of the national research institutes (or the designees of the Directors).

''(3) The Director of the Office shall serve as the Chair of the Coordinating Committee.

''(4) With respect to research on primary care and prevention, the Coordinating Committee shall assist the Director of the Office in—

''(A) identifying the need for such research, and making an estimate each fiscal year of the funds needed to adequately support the research; and

''(B) identifying needs regarding the coordination of research activities, including intramural and extramural multidisciplinary activities.

''(d) ADVISORY COMMITTEE.—

''(1) In carrying out subsection (b), the Director of the Office shall establish an advisory committee to be known as the Advisory Committee on Research on Primary Care and Prevention Research (in this subsection referred to as the 'Advisory Committee').

''(2) The Advisory Committee shall be composed of 14 individuals who are not officers or employees of the Federal Government. The Director of the Office shall make appointments to the Advisory Committee from among physicians, practitioners, scientists, and other health professionals whose clinical practice, research specialization, or professional expertise includes a significant focus on research on primary care and prevention.

''(3) The Director of the Office shall serve as the Chair of the Advisory Committee.

''(4) The Advisory Committee shall—

''(A) advise the Director of the Office on appropriate research activities to be undertaken by the national research institutes with respect to—

''(i) primary care and prevention, and

''(ii) research on primary care and prevention which requires a multidisciplinary approach;

''(B) report to the Director of the Office on such research; and

''(C) provide recommendations to such Director regarding activities of the Office (including recommendations on priorities in carrying out research described in subparagraph (A)).

''(5)(A) The Advisory Committee shall prepare a biennial report describing the activities of the Committee, including findings made by the Committee regarding—

''(i) the extent of expenditures made for research on primary care and prevention by the agencies of the National Institutes of Health; and

''(ii) the level of funding needed for such research.

''(B) The report required in subparagraph (A) shall be submitted to the Director of NIH for inclusion in the report required in section 403.

''(e) PRIMARY CARE AND PREVENTION RESEARCH DEFINED.—For purposes of this part, the term 'primary care and prevention research' means research on improvement of the practice of family medicine, general internal medicine, and general pediatrics, and includes research relating to—

''(1) obstetrics and gynecology, dentistry, or mental health or substance abuse treatment when provided by a primary care physician or other primary care practitioner, and

''(2) primary care provided by multidisciplinary teams.

"SEC. 486A. NATIONAL DATA SYSTEM AND CLEARINGHOUSE ON PRIMARY CARE AND PREVENTION RESEARCH.

''(a) DATA SYSTEM.—The Director of NIH, in consultation with the Director of the Office, shall establish a data system for the collection, storage, analysis, retrieval, and dissemination of information regarding primary care and prevention research that is conducted or

supported by the national research institutes. Information from the data system shall be available through information systems available to health care professionals and providers, researchers, and members of the public.

''(b) CLEARINGHOUSE.—The Director of NIH, in consultation with the Director of the Office and with the National Library of Medicine, shall establish, maintain, and operate a program to provide, and encourage the use of, information on research and prevention activities of the national research institutes that relate to primary care and prevention research.

"**SEC. 486B. BIENNIAL REPORT.**

''(a) IN GENERAL.—With respect to primary care and prevention research, the Director of the Office shall, not later than one year after the date of the enactment of this part, and biennially thereafter, prepare a report—

''(1) describing and evaluating the progress made during the preceding two fiscal years in research and treatment conducted or supported by the National Institutes of Health;

''(2) summarizing and analyzing expenditures made by the agencies of such Institutes (and by such Office) during the preceding two fiscal years; and

''(3) making such recommendations for legislative and administrative initiatives as the Director of the Office determines to be appropriate.

''(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR OF NIH.—The Director of the Office shall submit each report prepared under subsection (a) to the Director of NIH for inclusion in the report submitted to the President and the Congress under section 403.''.

(b) REQUIREMENT OF SUFFICIENT ALLOCATION OF RESOURCES OF INSTITUTES.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (10), by striking ''and'' after the semicolon at the end;

(2) in paragraph (11), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (11) the following new paragraph:

''(12) after consultation with the Director of the Office of Primary Care and Prevention Research, shall ensure that resources of the National Institutes of Health are sufficiently allocated for projects on primary care and prevention research that are identified under section 486(b).''.

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 408 of the Public Health Service Act (42 U.S.C. 284(a))

is amended by adding at the end the following new paragraph:

''(3) For the Office of Primary Care and Prevention Research, there are authorized to be appropriated $150,000,000 for fiscal year 1994, $180,000,000 for fiscal year 1995, and $216,000,000 for fiscal year 1996.''.

(d) CONFORMING AMENDMENT.—Section 485(g) of the Public Health Service Act (42 U.S.C. 287c–2(g)) is amended by striking ''section 486'' and inserting ''section 485A''.

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH SECURITY TRUST FUND

SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO APPLY.

(a) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(b) SECTION 15 NOT TO APPLY.—The amendments made by subtitle B shall not be treated as a change in

a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

Subtitle A—AMERICAN HEALTH SECURITY TRUST FUND

SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the American Health Security Trust Fund (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 1995), out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the aggregate increase in tax liabilities under the Internal Revenue Code of 1986 which is attributable to the application of the amendments made by this title. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund,

such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 1995) the amounts that would otherwise have been appropriated to carry out the following programs (and any other Federal program identified by the Board, in consultation with the Secretary of the Treasury, as providing for payment for health services the payment of which may be made under this Act):

(A) The medicare program, under parts A and B of title XVIII of the Social Security Act (other than amounts attributable to any premiums under such parts).

(B) The medicaid program, under State plans approved under title XIX of such Act.

(C) The Federal employees health benefit program, under chapter 89 of title 5, United States Code.

(D) The CHAMPUS program, under chapter 55 of title 10, United States Code.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act shall apply to the Trust Fund under this Act in the same manner as they applied to the Federal Hospital Insurance Trust Fund under part A of title XVIII of such Act, except that the American Health Security Standards Board shall constitute the Board of Trustees of the Trust Fund.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund after the settlement of claims for payments under title XVIII have been completed, shall be transferred into the American Health Security Trust Fund.

Subtitle B—Increases in Corporate and Individual Income Tax Rates; Health Security Premium; Surtax on Individuals With Incomes Over $1,000,000

SEC. 811. INCREASES IN REGULAR INCOME TAX RATES.

(a) INCREASE IN TOP CORPORATE INCOME TAX RATE.—Subparagraph (C) of section 1(b)(1) (relating to tax imposed on corporations) is amended by striking ''34 percent'' and inserting ''38 percent''.

(b) INCREASE IN INDIVIDUAL INCOME TAXES.—Section 1 (relating to tax imposed) as amended by striking subsections (a) through (e) and inserting the following:

''(a) MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.—There is hereby imposed on the taxable income of—

''(1) every married individual (as defined in section 7703) who makes a single return jointly with his spouse under section 6013, and

''(2) every surviving spouse (as defined in section 2(a)), a tax determined in accordance with the following table:

"If taxable income is:	**The tax is:**
Not over $38,000	15% of taxable income.
Over $38,000 but not over $91,900.	$5,700, plus 30% of the excess over $38,000.
Over $91,900 but not over $200,000.	$22,409, plus 34% of the excess over $91,900.

"If taxable income is:	The tax is:
Over $200,000	$59,163, plus 38% of the excess over $200,000.

''(b) HEADS OF HOUSEHOLDS.—There is hereby imposed on the taxable income of every head of a household (as defined in section 2(b)) a tax determined in accordance with the following table:

"If taxable income is:	The tax is:
Not over $30,500	15% of taxable income.
Over $30,500 but not over $78,750.	$4,575, plus 30% of the excess over $30,500.
Over $78,750 but not over $172,000.	$19,532.50, plus 34% of the excess over $78,750.
Over $172,000	$51,237.50, plus 38% of the excess over $172,000.

''(c) UNMARRIED INDIVIDUALS (OTHER THAN SURVIVING SPOUSES AND HEADS OF HOUSEHOLDS).—There is hereby imposed on the taxable income of every individual (other than a surviving spouse as defined in section 2(a) or the head of a household as defined in section 2(b)) who is not a married individual (as defined in section 770) a tax determined in accordance with the following table:

"If taxable income is:	The tax is:
Not over $22,750	15% of taxable income.
Over $22,750 but not over $55,150.	$3,412.50, plus 30% of the excess over $22,750.
Over $55,150 but not over $120,000.	$13,456.50, plus 34% of the excess over $55,150.
Over $120,000	$35,505, plus 38% of the excess over $120,000.

''(d) MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—There is hereby imposed on the taxable income of every married individual (as defined in section 7703) who does not make a single return jointly with his spouse

under section 6013, a tax determined in accordance with the following table:

"If taxable income is:	The tax is:
Not over $19,000	15% of taxable income.
Over $19,000 but not over $45,950.	$2,850, plus 30% of the excess over $19,000.
Over $45,950 but not over $100,000.	$11,204.50, plus 34% of the excess over $45,950.
Over $100,000	$29,581.50, plus 38% of the excess over $100,000.

''(e) ESTATES AND TRUSTS.—There is hereby imposed on the taxable income of—

''(1) every estate, and

''(2) every trust,

taxable under this subsection a tax determined in accordance with the following table:

"If taxable income is:	The tax is:
Not over $3,000	15% of taxable income.
Over $3,000 but not over $5,000	$450, plus 30% of the excess over $3,000.
Over $5,000 but not over $7,000	$1,070, plus 34% of the excess over $5,000.
Over $7,000	$1,750, plus 38% of the excess over $7,000.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 541 is amended by striking ''28 percent'' and inserting ''30 percent''.

(2)(A) Subsection (f) of section 1 is amended—

(i) by striking ''1990'' in paragraph (1) and inserting ''1995'', and

(ii) by striking ''1989'' in paragraph (3)(B) and inserting ''1994''.

(B) Subparagraph (B) of section 32(i)(1) is amended by striking ''1989'' and inserting ''1994''.

(C) Subparagraph (C) of section 41(e)(5) is amended by striking ''1989'' each place it appears and inserting ''1994''.

(D) Subparagraph (B) of section 63(c)(4) is amended by striking ''1989'' and inserting ''1994''.

(E) Subparagraph (B) of section 68(b)(2) is amended by striking ''1989'' and inserting ''1994''.

(F) Subparagraphs (A)(ii) and (B)(ii) of section 151(d)(4) are each amended by striking ''1989'' and inserting ''1994''.

(G) Clause (ii) of section 513(h)(2)(C) is amended by striking ''1989'' and inserting ''1994''.

(H) Subsection (a) of section 1201 is amended by striking ''34 percent'' each place it appears and inserting ''38 percent''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 812. INCREASES IN MINIMUM TAX RATES.

(a) IN GENERAL.—Subparagraph (A) of section 55(b)(1) (relating to tentative minimum tax) is amended by striking ''20 percent (24 percent'' and inserting ''25 percent (28 percent''.

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 897(a) is amended by striking ''21'' in the heading of such paragraph and in subparagraph (A) and inserting ''28''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 813. HEALTH SECURITY PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

''PART VIII—HEALTH SECURITY PREMIUM

''Sec. 59B. Imposition of premium.

''SEC. 59B. IMPOSITION OF PREMIUM.

''(a) GENERAL RULE.—In the case of an individual—

''(1) the amount of the tax imposed under section 1 for such taxable year shall be increased by 7.5 percent of the tax imposed under section 1 for such taxable year (determined without regard to this paragraph and section 59C), and

''(2) the amount of the tentative minimum tax determined under section 55 for such taxable year shall be increased by 7.5 percent of the amount of the tentative minimum tax for such taxable year (de-

termined without regard to this paragraph and 59D).

''(b) SPECIAL RULES.—

''(1) SURTAX TO APPLY TO ESTATES AND TRUSTS.—For purposes of this section, the term 'individual' includes any estate or trust taxable under section 1.

''(2) COORDINATION WITH OTHER PROVISIONS.—The provisions of this section shall be applied—

''(A) shall be applied after the application of section 1(h), but

''(B) before the application of any other provision of this title which refers to the amount of tax imposed by section 1 or 55, as the case may be.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

''Part VIII. Health security premium.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

SEC. 814. SURTAX ON INDIVIDUALS WITH INCOMES OVER $1,000,000.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

"PART IX—SURTAX ON INDIVIDUALS WITH INCOMES OVER $1,000,000

"SEC. 59C. SURTAX ON SECTION 1 TAX.

''In the case of an individual who has taxable income for the taxable year in excess of $1,000,000, the amount of the tax imposed under section 1 for such taxable year shall be increased by 10 percent of the amount which bears the same ratio to the tax imposed under section 1 (determined without regard to this section and section 59B) as—

''(1) the amount by which the taxable income of such individual for such taxable year exceeds $1,000,000, bears to

''(2) the total amount of such individual's taxable income for such taxable year.

"SEC. 59D. SURTAX ON MINIMUM TAX.

''In the case of an individual who has alternative minimum taxable income for the taxable year in excess of $1,000,000, the amount of the tentative minimum tax de-

termined under section 55 for such taxable year shall be increased by 2.8 percent of the amount by which the alternative minimum taxable income of such taxpayer for the taxable year exceeds $1,000,000.

"SEC. 59E. SPECIAL RULES.

''(a) SURTAX TO APPLY TO ESTATES AND TRUSTS.—For purposes of this part, the term 'individual' includes any estate or trust taxable under section 1.

''(b) TREATMENT OF MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—In the case of a married individual (within the meaning of section 7703) filing a separate return for the taxable year, sections 59C and 59D shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) COORDINATION WITH OTHER PROVISIONS.—The provisions of this part—

''(1) shall be applied after the application of sections 1(h) and 59B, but

''(2) before the application of any other provision of this title which refers to the amount of tax imposed by section 1 or 55, as the case may be.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

''Part IX. Surtax on individuals with incomes over $1,000,000.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

Subtitle C—Employment Tax Changes

SEC. 821. MODIFICATIONS OF CERTAIN EMPLOYMENT TAX PROVISIONS.

(a) INCREASE IN EMPLOYER HOSPITAL INSURANCE TAX; REPEAL OF DOLLAR LIMITATION ON AMOUNT OF WAGES SUBJECT TO EMPLOYEE AND EMPLOYER HOSPITAL INSURANCE TAXES.—

(1) EMPLOYEE TAX.—Subsection (b) of section 3101 is amended by striking ''equal to'' and all that follows and inserting ''equal to 1.45 percent of the wages (as defined in section 3121(a) without regard to paragraph (1) thereof) received by him with respect to employment (as defined in section 3121(b))''.

(2) EMPLOYER TAX.—Subsection (b) of section 3111 is amended by striking ''equal to'' and all that follows and inserting ''equal to 7.9 percent of the wages (as defined in section 3121(a) without regard to paragraph (1) thereof) paid by him with respect to employment (as defined in section 3121(b))''.

(3) SELF-EMPLOYMENT TAX.—Subsection (b) of section 1401 is amended by striking ''a tax as follows:'' and all that follows and inserting ''a tax equal to 8.35 percent of the amount of the self-employment income (as defined in section 1402(b) without regard to paragraph (1) thereof) for such taxable year''.

(4) RAILROAD RETIREMENT TAXES.—Subparagraph (A) of section 3231(e)(2) is amended by adding at the end thereof the following new clause:

''(iii) LIMITATION NOT TO APPLY TO TAXES EQUIVALENT TO HOSPITAL INSURANCE TAXES.—Clause (i) shall not apply to—

''(I) so much of the rate applicable under section 3201(a) or 3221(a) (as the case may be) as does not exceed the rate of tax in effect under section 3101(b), and

''(II) so much of the rate of tax applicable under section 3211(a)(1) as does not exceed the rate of tax in effect under section 1401(b).''.

(5) TECHNICAL AMENDMENTS.—

(A) Subsection (b) of section 1402 is amended by striking ''the applicable contribution base (as determined under subsection (k))'' and inserting ''the contribution and benefit base (as determined under section 231 of the Social Security Act)''.

(B) Section 1402 is amended by striking subsection (k).

(C) Paragraph (1) of section 3121(a) is amended—

(i) by striking ''applicable contribution base (as determined under subsection (x))'' each place it appears and inserting ''contribution and benefit base (as determined under section 230 of the Social Security Act)'', and

(ii) by striking ''such applicable contribution base'' and inserting ''such contribution and benefit base''.

(D) Section 3121 is amended by striking subsection (x).

(E) Clause (i) of section 3231(e)(2)(B) is amended to read as follows:

''(i) TIER 1 TAXES.—Except as provided in clause (ii), the term 'applicable

base' means for any calendar year the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.''

(F) Paragraph (3) of section 6413(c) is amended to read as follows:

''(3) SEPARATE APPLICATION FOR HOSPITAL INSURANCE TAXES.—Paragraphs (1) and (2) shall not apply to—

''(A) the tax imposed by section 3101(b) (or any amount equivalent to such tax), and

''(B) so much of the tax imposed by section 3201 as is determined at a rate not greater than the rate in effect under section 3101(b).''.

(G) Sections 3122 and 3125 are each amended—

(i) by striking ''section 3111'' each place it appears and inserting ''section 3111(a)'', and

(ii) by striking ''applicable contribution base limitation'' and inserting ''contribution and benefit base limitation''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall apply to 1994 and later calendar years.

(b) ADDITIONAL STATE AND LOCAL EMPLOYEES SUBJECT TO HOSPITAL INSURANCE TAX.—

(1) IN GENERAL.—Paragraph (2) of section 3121(u) is amended by striking subparagraphs (C) and (D).

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to remuneration paid after December 31, 1994.

Subtitle D—Other Revenue Increases Primarily Affecting Individuals

SEC. 831. OVERALL LIMITATION ON ITEMIZED DEDUCTIONS FOR HIGH-INCOME TAXPAYERS MADE PERMANENT.

Subsection (f) of section 68 (relating to overall limitation on itemized deductions) is hereby repealed.

SEC. 832. PHASEOUT OF PERSONAL EXEMPTION OF HIGH-INCOME TAXPAYERS MADE PERMANENT.

Section 151(d)(3) (relating to phaseout of personal exemption) is amended by striking subparagraph (E).

SEC. 833. MODIFICATIONS TO DEDUCTIONS FOR CERTAIN MOVING EXPENSES.

(a) REPEAL OF DEDUCTION FOR QUALIFIED RESIDENCE SALE, ETC., EXPENSES.—

(1) IN GENERAL.—Paragraph (1) of section 217(b) (defining moving expenses) is amended by inserting ''or'' at the end of subparagraph (C), by striking '', or'' at the end of subparagraph (D) and inserting a period, and by striking subparagraph (E).

(2) CONFORMING AMENDMENTS.—

(A) Subsection (b) of section 217 is amended by striking paragraph (2) and redesignating paragraph (3) as paragraph (2).

(B) Section 217 is amended by striking subsection (e).

(b) DEDUCTION DISALLOWED FOR MEAL EXPENSES.—Paragraph (1) of section 217(b) is amended—

(1) by striking ''meals and lodging'' in subparagraphs (B), (C) and (D) and inserting ''lodging'', and

(2) by adding at the end thereof the following new sentence:

''Such term shall not include any expenses for meals.''.

(c) OVERALL LIMITATION.—

(1) IN GENERAL.—Subparagraph (A) of section 217(b)(2) (as redesignated by subsection (a)) is amended to read as follows:

''(A) DOLLAR LIMITS.—The aggregate amount allowable as a deduction under subsection (a) in connection with a commencement of work shall not exceed $5,000. The aggregate amount allowable as a deduction under subsection (a) in connection with a commencement of work which is attributable to expenses described in subparagraphs (C) or (D) of paragraph (1) shall not exceed $1,500.''.

(2) CONFORMING AMENDMENTS.—

(A) Subparagraph (B) of section 217(b)(2) (as so redesignated) is amended by striking the second sentence and inserting the following: ''In the case of a husband and wife filing separate returns, subparagraph (A) shall be applied by substituting '$750' for '$1,500', and by substituting '$2,500' for '$5,000'.''.

(B) Paragraph (1) of section 217(h) is amended by striking subparagraphs (B) and (C) and inserting the following:

''(B) subsection (b)(2)(A) shall be applied by substituting '$4,500' for '$1,500', and

''(C) appropriate adjustments to the application of the last sentence of subsection (b)(2)(B) shall be made to take into account

the provisions of subparagraph (B) of this paragraph.''.

(d) INCREASE IN MILEAGE REQUIREMENTS.—Paragraph (1) of section 217(c) is amended by striking ''35 miles'' each place it appears and inserting ''60 miles''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 834. TOP ESTATE AND GIFT TAX RATES MADE PERMANENT.

(a) GENERAL RULE.—The table contained in paragraph (1) of section 2001(c) is amended by striking the last item and inserting the following new items:

''Over $2,500,000 but not over $3,000,000.	$1,025,800, plus 53% of the excess over $2,500,000.
Over $3,000,000	$1,290,800, plus 55% of the excess over $3,000,000.''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (c) of section 2001 is amended by striking paragraph (2) and by redesignating paragraph (3) as paragraph (2).

(2) Paragraph (2) of section 2001(c), as redesignated by paragraph (1), is amended by striking ''($18,340,000 in the case of decedents dying, and gifts made, after 1992)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply in the case of decedents dying, and gifts made, after December 31, 1994.

SEC. 835. ELIMINATION OF DEDUCTION FOR CLUB MEMBERSHIP FEES.

(a) IN GENERAL.—Subsection (a) of section 274 (relating to disallowance of certain entertainment, etc., expenses) is amended by adding at the end thereof the following new paragraph:

''(3) DENIAL OF DEDUCTION FOR CLUB DUES.—Notwithstanding the preceding provisions of this subsection, no deduction shall be allowed under this chapter for amounts paid or incurred for membership in any club organized for business, pleasure, recreation, or other social purpose.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to amounts paid or incurred after December 31, 1994.

SEC. 836. INCREASE OF SOCIAL SECURITY BENEFITS INCLUDED IN INCOME.

(a) IN GENERAL.—Subsections (a) and (b) of section 86 are each amended by striking ''one-half'' each place it appears and inserting ''85 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 837. LONG-TERM HEALTH CARE PREMIUM FOR THE ELDERLY.

(a) IN GENERAL.—Except as provided in subsection (b), each individual who at any time in a month is 65 years of age or older and is eligible for benefits under title XXI of the Social Security Act in the month shall pay a long-term care/health care premium for the month of $65.

(b) EXCEPTION FOR LOW-INCOME ELDERLY.—The Secretary of Health and Human Services shall provide a process whereby individuals with an adjusted gross income which does not exceed $8,500 (or $10,700 in the case of joint adjusted gross income in the case of a married individual) are not liable for the premium imposed under paragraph (1).

(c) COLLECTION OF PREMIUM.—The premium imposed under this section shall be collected in the same manner (including deduction from Social Security checks) as the premium imposed under part B of title XVIII of the Social Security Act was collected under section 1840 of such Act as of the date of the enactment of this Act.

(d) DEPOSIT INTO NATIONAL HEALTH TRUST FUND.—Premiums collected under this section shall be transferred to and deposited into the National Health Trust Fund in the same manner as premiums collected under section 1840 of the Social Security Act were transferred and deposited into the Federal Supplementary Medical Insurance Trust Fund.

(e) COST-OF-LIVING ADJUSTMENT.—In the case of months beginning in any calendar year after 1996, each of the dollar amounts contained in subsections (a) and (b) shall be increased by an amount equal to such dollar amount, multiplied by the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for the calendar year in which the month begins.

(f) APPLICATION OF SECTION.—This section shall apply to months beginning after December 31, 1994.

Subtitle E—Other Revenue Increases Primarily Affecting Businesses

SEC. 841. MARK TO MARKET ACCOUNTING METHOD FOR SECURITIES DEALERS.

(a) GENERAL RULE.—Subpart D of part II of subchapter E of chapter 1 (relating to inventories) is amended by adding at the end thereof the following new section:

"SEC. 475. MARK TO MARKET ACCOUNTING METHOD FOR DEALERS IN SECURITIES.

''(a) GENERAL RULE.—Notwithstanding any other provision of this subpart, the following rules shall apply to securities held by a dealer in securities:

''(1) Any security which is inventory in the hands of the dealer shall be included in inventory at its fair market value.

''(2) In the case of any security which is not inventory in the hands of the dealer and which is held at the close of any taxable year—

''(A) the dealer shall recognize gain or loss as if such security were sold for its fair market value on the last business day of such taxable year, and

''(B) any gain or loss shall be taken into account for such taxable year.

Proper adjustment shall be made in the amount of any gain or loss subsequently realized for gain or loss taken into account under the preceding sentence. The Secretary may provide by regulations for the application of this paragraph at times other than the times provided in this paragraph.

''(b) EXCEPTIONS.—

''(1) IN GENERAL.—Subsection (a) shall not apply to—

''(A) any security held for investment,

''(B)(i) any security described in subsection (c)(2)(C) which is acquired (including originated) by the taxpayer in the ordinary course of a trade or business of the taxpayer and which is not held for sale, and (ii) any obligation to acquire a security described in clause (i) if such obligation is entered into in the ordinary course of such trade or business and is not held for sale, and

''(C) any security which is a hedge with respect to—

''(i) a security to which subsection (a) does not apply, or

''(ii) a position, right to income, or a liability which is not a security in the hands of the taxpayer.

To the extent provided in regulations, subparagraph (C) shall not apply to any security held by a person in its capacity as a dealer in securities.

''(2) IDENTIFICATION REQUIRED.—A security shall not be treated as described in subparagraph (A), (B), or (C) of paragraph (1), as the case may be, unless such security is clearly identified in the dealer's records as being described in such subpara-

graph before the close of the day on which it was acquired, originated, or entered into (or such other time as the Secretary may by regulations prescribe).

''(3) SECURITIES SUBSEQUENTLY NOT EXEMPT.—If a security ceases to be described in paragraph (1) at any time after it was identified as such under paragraph (2), subsection (a) shall apply to any changes in value of the security occurring after the cessation.

''(4) SPECIAL RULE FOR PROPERTY HELD FOR INVESTMENT.—To the extent provided in regulations, subparagraph (A) of paragraph (1) shall not apply to any security described in subparagraph (D) or (E) of subsection (c)(2) which is held by a dealer in such securities.

''(c) DEFINITIONS.—For purposes of this section—

''(1) DEALER IN SECURITIES DEFINED.—The term 'dealer in securities' means a taxpayer who—

''(A) regularly purchases securities from or sells securities to customers in the ordinary course of a trade or business; or

''(B) regularly offers to enter into, assume, offset, assign or otherwise terminate positions in securities with customers in the ordinary course of a trade or business.

''(2) SECURITY DEFINED.—The term 'security' means any—

''(A) share of stock in a corporation;

''(B) partnership or beneficial ownership interest in a widely held or publicly traded partnership or trust;

''(C) note, bond, debenture, or other evidence of indebtedness;

''(D) interest rate, currency, or equity notional principal contract;

''(E) evidence of an interest in, or a derivative financial instrument in, any security described in subparagraph (A), (B), (C), or (D), or any currency, including any option, forward contract, short position, and any similar financial instrument in such a security or currency; and

''(F) position which—

''(i) is not a security described in subparagraph (A), (B), (C), (D), or (E),

''(ii) is a hedge with respect to such a security, and

''(iii) is clearly identified in the dealer's records as being described in this subparagraph before the close of the day on

which it was acquired or entered into (or such other time as the Secretary may by regulations prescribe).

Subparagraph (E) shall not include any contract to which section 1256(a) applies.

''(3) HEDGE.—The term 'hedge' means any position which reduces the dealer's risk of interest rate or price changes or currency fluctuations, including any position which is reasonably expected to become a hedge within 60 days after the acquisition of the position.

''(d) SPECIAL RULES.—For purposes of this section—

''(1) COORDINATION WITH CERTAIN RULES.—The rules of sections 263(g), 263A, and 1256(a) shall not apply to securities to which subsection (a) applies, and section 1091 shall not apply (and section 1092 shall apply) to any loss recognized under subsection (a).

''(2) IMPROPER IDENTIFICATION.—If a taxpayer—

''(A) identifies any security under subsection (b)(2) as being described in subsection (b)(1) and such security is not so described, or

''(B) fails under subsection (c)(2)(F)(iii) to identify any position which is described in subsection (c)(2)(F) (without regard to clause (iii) thereof) at the time such identification is required,

the provisions of subsection (a) shall apply to such security or position, except that any loss under this section prior to the disposition of the security or position shall be recognized only to the extent of gain previously recognized under this section (and not previously taken into account under this paragraph) with respect to such security or position.

''(3) CHARACTER OF GAIN OR LOSS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) or section 1236(b)—

''(i) IN GENERAL.—Any gain or loss with respect to a security under subsection (a)(2) shall be treated as ordinary income or loss.

''(ii) SPECIAL RULE FOR DISPOSITIONS.—If—

''(I) gain or loss is recognized with respect to a security before the close of the taxable year, and

''(II) subsection (a)(2) would have applied if the security were held as of the close of the taxable year,

such gain or loss shall be treated as ordinary income or loss.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to any gain or loss which is allocable to a period during which—

''(i) the security is described in subsection (b)(1)(C) (without regard to subsection (b)(2)),

''(ii) the security is held by a person other than in connection with its activities as a dealer in securities, or

''(iii) the security is improperly identified (within the meaning of subparagraph (A) or (B) of paragraph (2)).

''(e) REGULATORY AUTHORITY.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section, including rules—

''(1) to prevent the use of year-end transfers, related parties, or other arrangements to avoid the provisions of this section, and

''(2) to provide for the application of this section to any security which is a hedge which cannot be identified with a specific security, position, right to income, or liability.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (1) of section 988(d) is amended—

(A) by striking ''section 1256'' and inserting ''section 475 or 1256'', and

(B) by striking ''1092 and 1256'' and inserting ''475, 1092, and 1256''.

(2) The table of sections for subpart D of part II of subchapter E of chapter 1 is amended by adding at the end thereof the following new item:

''Sec. 475. Mark to market accounting method for dealers in securities.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to all taxable years ending on or after December 31, 1994.

(2) CHANGE IN METHOD OF ACCOUNTING.—In the case of any taxpayer required by this section to change its method of accounting for any taxable year—

(A) such change shall be treated as initiated by the taxpayer,

(B) such change shall be treated as made with the consent of the Secretary, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481 of the Internal Revenue Code of 1986 shall be taken into account ratably over the 4-taxable year period beginning with the first taxable year ending on or after December 31, 1994.

SEC. 842. INCREASE IN RECOVERY PERIOD FOR NONRESIDENTIAL REAL PROPERTY.

(a) GENERAL RULE.—Paragraph (1) of section 168(c) (relating to applicable recovery period) is amended by striking the item relating to nonresidential real property and inserting the following:

''Nonresidential real property ..... 40 years.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to property placed in service by the taxpayer after December 31, 1994.

(2) EXCEPTION.—The amendments made by this section shall not apply to property placed in service by the taxpayer before January 1, 1996, if—

(A) the taxpayer or a qualified person entered into a binding written contract to pur-

chase or construct such property before December 31, 1994, or

(B) the construction of such property was commenced by or for the taxpayer or a qualified person before December 31, 1994.

For purposes of this paragraph, the term ''qualified person'' means any person who transfers his rights in such a contract or such property to the taxpayer but only if the property is not placed in service by such person before such rights are transferred to the taxpayer.

SEC. 843. TAXATION OF INCOME OF CONTROLLED FOREIGN CORPORATIONS ATTRIBUTABLE TO IMPORTED PROPERTY.

(a) GENERAL RULE.—Subsection (a) of section 954 (defining foreign base company income) is amended by striking ''and'' at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting '', and'', and by adding at the end thereof the following new paragraph:

''(6) imported property income for the taxable year (determined under subsection (h) and reduced as provided in subsection (b)(5)).''.

(b) DEFINITION OF IMPORTED PROPERTY INCOME.—Section 954 is amended by adding at the end thereof the following new subsection:

''(h) IMPORTED PROPERTY INCOME.—

''(1) IN GENERAL.—For purposes of subsection (a)(6), the term 'imported property income' means income (whether in the form of profits, commissions, fees, or otherwise) derived in connection with—

''(A) manufacturing, producing, growing, or extracting imported property,

''(B) the sale, exchange, or other disposition of imported property, or

''(C) the lease, rental, or licensing of imported property.

Such term shall not include any foreign oil and gas extraction income (within the meaning of section 907(c)) or any foreign oil related income (within the meaning of section 907(c)).

''(2) IMPORTED PROPERTY.—For purposes of this subsection—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'imported property' means property which is imported into the United States by the controlled foreign corporation or a related person.

''(B) IMPORTED PROPERTY INCLUDES CERTAIN PROPERTY IMPORTED BY UNRELATED PERSONS.—The term 'imported property' includes any property imported into the United States by an unrelated person if, when such property was sold to the unrelated person by the controlled foreign corporation (or a related person), it was reasonable to expect that—

''(i) such property would be imported into the United States, or

''(ii) such property would be used as a component in other property which would be imported into the United States.

''(C) EXCEPTION FOR PROPERTY SUBSEQUENTLY EXPORTED.—The term 'imported property' does not include any property which is imported into the United States and which—

''(i) before substantial use in the United States, is sold, leased, or rented by the controlled foreign corporation or a related person for direct use, consumption, or disposition outside the United States, or

''(ii) is used by the controlled foreign corporation or a related person as a com-

ponent in other property which is so sold, leased, or rented.

''(3) DEFINITIONS AND SPECIAL RULES.—

''(A) IMPORT.—For purposes of this subsection, the term 'import' means entering, or withdrawal from warehouse, for consumption or use. Such term includes any grant of the right to use an intangible (as defined in section 936(b)(3)(B)) in the United States.

''(B) UNRELATED PERSON.—For purposes of this subsection, the term 'unrelated person' means any person who is not a related person with respect to the controlled foreign corporation.

''(C) COORDINATION WITH FOREIGN BASE COMPANY SALES INCOME.—For purposes of this section, the term 'foreign base company sales income' shall not include any imported property income.''.

(c) SEPARATE APPLICATION OF LIMITATIONS ON FOREIGN TAX CREDIT FOR IMPORTED PROPERTY INCOME.—

(1) IN GENERAL.—Paragraph (1) of section 904(d) (relating to separate application of section with respect to certain categories of income) is

amended by striking ''and'' at the end of subparagraph (H), by redesignating subparagraph (I) as subparagraph (J), and by inserting after subparagraph (H) the following new subparagraph:

''(I) imported property income, and''.

(2) IMPORTED PROPERTY INCOME DEFINED.—Paragraph (2) of section 904(d) is amended by redesignating subparagraphs (H) and (I) as subparagraphs (I) and (J), respectively, and by inserting after subparagraph (G) the following new subparagraph:

''(H) IMPORTED PROPERTY INCOME.—The term 'imported property income' means any income received or accrued by any person which is of a kind which would be imported property income (as defined in section 954(h)).''

(3) LOOK-THRU RULES TO APPLY.—Subparagraph (F) of section 904(d)(3) is amended by striking ''or (E)'' and inserting ''(E), or (H)''.

(d) TECHNICAL AMENDMENTS.—

(1) Clause (iii) of section 952(c)(1)(B) (relating to certain prior year deficits may be taken into account) is amended by inserting the following subclause after subclause (II) (and by redesignating the following subclauses accordingly):

''(III) imported property income,''.

(2) Paragraph (5) of section 954(b) (relating to deductions to be taken into account) is amended by striking ''and the foreign base company oil related income'' and inserting ''the foreign base company oil related income, and the imported property income''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years of foreign corporations beginning after December 31, 1994, and to taxable years of United States shareholders within which or with which such taxable years of such foreign corporations end.

(2) SUBSECTION (C).—The amendments made by subsection (c) shall apply to taxable years beginning after December 31, 1994.

SEC. 844. REPEAL OF DEDUCTION FOR INTANGIBLE DRILLING AND DEVELOPMENT COSTS.

(a) IN GENERAL.—Subsection (c) of section 263 (relating to capital expenditures) is hereby repealed.

(b) CONFORMING AMENDMENT.—Section 57 (relating to items of tax preference) is amended by striking subsections (a)(2) and (b).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to costs paid or incurred after December 31, 1994, in taxable years ending after such date.

SEC. 845. REPEAL OF PERCENTAGE DEPLETION FOR OIL AND GAS WELLS.

(a) IN GENERAL.—Section 613A is hereby repealed.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 613 (relating to percentage depletion) is amended by striking ''Except as provided in section 613A, in'' and inserting ''In''.

(2) Paragraph (1) of section 57(a) is amended by striking the last sentence.

(3) The table of sections for part I of subchapter I of chapter 1 is amended by striking the item relating to section 613A.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 846. REPEAL OF APPLICATION OF LIKE-KIND EXCHANGE RULES TO REAL PROPERTY.

(a) IN GENERAL.—Paragraph (2) of section 1031(a) (relating to exchange of property held for productive use or investment) is amended by striking ''or'' at the end of subparagraph (E), by striking the period at the end of

subparagraph (F) and inserting ‘‘, or’’, and by adding at the end thereof the following new subparagraph:

‘‘(G) real property.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to transfers after December 31, 1994.

SEC. 847. AMORTIZATION OF PORTION OF ADVERTISING EXPENSES.

(a) IN GENERAL.—Part IX of subchapter B of chapter 1 (relating to items not deductible) is amended by inserting after section 263A the following new section:

‘‘SEC. 263B. CAPITALIZATION OF PORTION OF ADVERTISING EXPENSES.

‘‘(a) 20 PERCENT OF ADVERTISING EXPENSES REQUIRED TO BE CAPITALIZED.—

‘‘(1) DISALLOWANCE.—Except as provided in paragraph (2), no deduction shall be allowed for 20 percent of the advertising expenses paid or incurred by the taxpayer during the taxable year.

‘‘(2) AMORTIZATION OF DISALLOWED AMOUNT.—The amount not allowed as a deduction under paragraph (1) for any taxable year—

‘‘(A) shall be treated as chargeable to capital account with respect to the trade or busi-

ness (or activity described in section 212) in which incurred, and

''(B) shall be allowed as a deduction ratably over the 48-month period beginning with the 1st month of the following taxable year.

''(b) ADVERTISING EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'advertising expense' means any amount—

''(A) which (without regard to this section) is allowable as a deduction under section 162 or 212 for the taxable year in which paid or incurred, and

''(B) which is paid or incurred in connection with an attempt to encourage the purchase or sale, lease, or use of any product or service for the benefit of the taxpayer or a related person by means of any media.

''(2) AMOUNTS DEDUCTIBLE AS DEPRECIATION OR AMORTIZATION TREATED AS EXPENSES.—The amount allowable as a deduction under this chapter for the taxable year for depreciation or amortization shall be treated for purposes of this section as an expense paid or incurred during such year which is described in paragraph (1).''.

(b) CLERICAL AMENDMENT.—The table of sections for such part IX is amended by inserting after the item relating to section 263A the following new item:

''Sec. 263B. Capitalization of portion of advertising expenses.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 1994, in taxable years ending after such date.

Subtitle F—Estimated Tax Provisions

SEC. 851. INDIVIDUAL ESTIMATED TAX PROVISIONS.

(a) GENERAL RULE.—Paragraph (1) of section 6654(d) (relating to amount of required installment) is amended—

(1) by striking ''100 percent'' in subparagraph (B)(ii) and inserting ''120 percent'', and

(2) by striking subparagraphs (C), (D), (E), and (F).

(b) CONFORMING AMENDMENTS.—

(1) Subparagraph (C) of section 6654(i)(1) is amended by striking ''and without regard to subparagraph (C) of subsection (d)(1)''.

(2) Subparagraph (A) of section 6654(j)(3) is amended by striking ''and subsection (d)(1)(C)(iii) shall not apply''.

(3) Paragraph (4) of section 6654(l) is amended by striking ''paragraphs (1)(C)(iv) and (2)(B)(i) of subsection (d)'' and inserting ''subsection (d)(2)(B)(i)''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

SEC. 852. CORPORATE ESTIMATED TAX PROVISIONS.

(a) INCREASE IN ESTIMATED TAX.—

(1) IN GENERAL.—Subsection (d) of section 6655 (relating to amount of required installments) is amended—

(A) by striking ''91 percent'' each place it appears in paragraph (1)(B)(i) and inserting ''100 percent'',

(B) by striking ''91 PERCENT'' in the heading of paragraph (2) and inserting ''100 PERCENT'', and

(C) by striking paragraph (3).

(2) CONFORMING AMENDMENTS.—

(A) Clause (ii) of section 6655(e)(2)(B) is amended by striking the table contained therein and inserting the following new table:

"In the case of the following required installments:	**The applicable percentage is:**
1st	25
2nd	50

3rd	75
4th	100.''.

(B) Clause (i) of section 6655(e)(3)(A) is amended by striking ''91 percent'' and inserting ''100 percent''.

(b) MODIFICATION OF PERIODS FOR APPLYING ANNUALIZATION.—

(1) Clause (i) of section 6655(e)(2)(A) is amended—

(A) by striking ''or for the first 5 months'' in subclause (II),

(B) by striking ''or for the first 8 months'' in subclause (III), and

(C) by striking ''or for the first 11 months'' in subclause (IV).

(2) Paragraph (2) of section 6655(e) is amended by adding at the end thereof the following new subparagraph:

''(C) ELECTION FOR DIFFERENT ANNUALIZATION PERIODS.—

''(i) If the taxpayer makes an election under this clause—

''(I) subclause (II) of subparagraph (A)(i) shall be applied by substituting '4 months' for '3 months',

''(II) subclause (III) of subparagraph (A)(i) shall be applied by substituting '7 months' for '6 months', and

''(III) subclause (IV) of subparagraph (A)(i) shall be applied by substituting '10 months' for '9 months'.

''(ii) If the taxpayer makes an election under this clause—

''(I) subclause (II) of subparagraph (A)(i) shall be applied by substituting '5 months' for '3 months',

''(II) subclause (III) of subparagraph (A)(i) shall be applied by substituting '8 months' for '6 months', and

''(III) subclause (IV) of subparagraph (A)(i) shall be applied by substituting '11 months' for '9 months'.

''(iii) An election under clause (i) or (ii) shall apply to the taxable year for which made and such an election shall be effective only if made on or before the date required for the payment of the second required installment for such taxable year.''.

(3) The last sentence of section 6655(f)(3)(A) is amended by striking ''and subsection (e)(2)(A)'' and inserting ''and, except in the case of an election under subsection (e)(2)(C), subsection (e)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

Subtitle G—Alternative Taxable Years

SEC. 861. ELECTION OF TAXABLE YEAR OTHER THAN REQUIRED TAXABLE YEAR.

(a) LIMITATIONS ON TAXABLE YEARS WHICH MAY BE ELECTED.—Subsection (b) of section 444 (relating to limitations on taxable years which may be elected) is amended to read as follows:

''(b) TAXABLE YEAR MUST BE SAME AS REPORTING PERIOD.—If an entity has annual reports or statements—

''(1) which ascertain income, profit, or loss of the entity, and

''(2) which are—

''(A) provided to shareholders, partners, or other proprietors, or

''(B) used for credit purposes,

the entity may make an election under subsection (a) only if the taxable year elected covers the same period as such reports or statements.''.

(b) PERIOD OF ELECTION.—Section 444(d)(2) (relating to period of election) is amended to read as follows:

''(2) PERIOD OF ELECTION.—

''(A) IN GENERAL.—An election under subsection (a) shall remain in effect until the partnership, S corporation, or personal service corporation terminates the election and adopts the required taxable year.

''(B) CHANGE NOT TREATED AS TERMINATION.—For purposes of subparagraph (A), a change from a taxable year which is not a required taxable year to another such taxable year shall not be treated as a termination.''.

(c) EXCEPTION FOR TRUSTS.—Section 444(d)(3) (relating to tiered structures) is amended by adding at the end thereof the following new subparagraph:

''(C) EXCEPTION FOR CERTAIN STRUCTURES THAT INCLUDE TRUSTS.—An entity shall not be considered to be part of a tiered structure to which subparagraph (A) applies solely because a trust owning an interest in such entity is a trust all of the beneficiaries of

which use a calendar year for their taxable year.''.

(d) REGULATIONS.—Subsection (g) of section 444 (relating to regulations) is amended to read as follows:

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations—

''(1) to prevent the avoidance of the provisions of this section through a change in entity or form of an entity,

''(2) to prevent the carryback to any preceding taxable year of a net operating loss (or similar item) arising in any short taxable year created pursuant to an election or termination of an election under this section, and

''(3) to provide for the termination of an election under subsection (a) if an entity does not continue to meet the requirements of subsection (b).''

SEC. 862. REQUIRED PAYMENTS FOR ENTITIES ELECTING NOT TO HAVE REQUIRED TAXABLE YEAR.

(a) ADDITIONAL REQUIRED PAYMENT.—

(1) IN GENERAL.—Section 7519(b) (defining required payment) is amended to read as follows:

''(b) REQUIRED PAYMENT.—For purposes of this section—

''(1) IN GENERAL.—The term 'required payment' means, with respect to any applicable election year of a partnership or S corporation, an amount equal to the excess (if any) of—

''(A) the adjusted highest section 1 rate, multiplied by the net base year income of the entity, over

''(B) the net required payment balance.

For purposes of paragraph (1)(A), the term 'adjusted highest section 1 rate' means the highest rate of tax in effect under section 1 as of the close of the first required taxable year ending within such year, plus 2 percentage points.

''(2) ADDITIONAL PAYMENT FOR NEW APPLICABLE ELECTION YEARS.—

''(A) IN GENERAL.—In the case of a new applicable election year, the required payment shall include, in addition to any amount determined under paragraph (1), the amount determined under subparagraph (C).

''(B) NEW APPLICABLE ELECTION YEAR.—For purposes of this section, the term 'new applicable election year' means any applicable election year—

''(i) with respect to which the preceding taxable year was not an applicable election year, or

''(ii) which covers a different period than the preceding taxable year by reason of a change described in section 444(d)(2)(B).

If any year described in the preceding sentence is a short taxable year which does not include the last day of the required taxable year, the new applicable election year shall be the taxable year following the short taxable year.

''(C) ADDITIONAL AMOUNT.—For purposes of subparagraph (A), the amount determined under this subparagraph shall be—

''(i) in the case of a year described in subparagraph (B)(i), 75 percent of the required payment for the year, and

''(ii) in the case of a year described in subparagraph (B)(ii), 75 percent of the excess (if any) of—

''(I) the required payment for the year, over

''(II) the required payment for the year which would have been com-

puted if the change described in subparagraph (B)(ii) had not occurred.

''(D) REQUIRED PAYMENT.—For purposes of this paragraph, the term 'required payment' means the payment required by this section (determined without regard to this paragraph).''.

(2) DUE DATE.—Paragraph (2) of section 7519(f) (defining due date) is amended to read as follows:

''(2) DUE DATE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amount of any required payment for any applicable election year shall be paid on or before May 15 of the calendar year following the calendar year in which the applicable election year begins.

''(B) SPECIAL RULE WHERE NEW APPLICABLE ELECTION YEAR ADOPTED.—In the case of a new applicable election year, the portion of any required payment determined under subsection (b)(2) shall be paid on or before September 15 of the calendar year in which the applicable election year begins.''.

(3) PENALTIES.—

(A) IN GENERAL.—Section 7519(f)(4) (relating to penalties) is amended by adding at the end thereof the following new subparagraph:

''(D) FAILURE TO PAY ADDITIONAL AMOUNT.—In the case of any failure by any entity to pay on the date prescribed therefore the portion of any required payment described in subsection (b)(2) for any applicable election year—

''(i) subparagraph (A) shall not apply, but

''(ii) the entity shall, for purposes of this title, be treated as having terminated the election under section 444 for such year and changed to the required taxable year.''.

(B) CONFORMING AMENDMENT.—Section 7519(f)(4)(A) is amended by striking ''In'' and inserting ''Except as provided in subparagraph (D), in''.

(4) REFUNDS.—Section 7519(c)(2)(A) (relating to refund of payments) is amended to read as follows:

''(A) an election under section 444 is not in effect for any year but was in effect for the preceding year, or''.

(5) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 7519(c) is amended—

(i) by striking ''subsection (b)(2)'' and inserting ''subsection (b)(1)(B)'', and

(ii) by striking ''subsection (b)(1)'' and inserting ''subsection (b)(1)(A)''.

(B) Subsection (d) of section 7519 is amended by striking paragraph (4) and redesignating paragraph (5) as paragraph (4).

(b) OTHER DEFINITIONS AND SPECIAL RULES.—

(1) REFUND.—Paragraph (3) of section 7519(c) (relating to date on which refund is payable) is amended in the matter preceding subparagraph (A) by striking ''on the later of'' and inserting ''by the later of''.

(2) DEFERRAL RATIO.—The last sentence of paragraph (1) of section 7519(d) is amended to read as follows: ''Except as provided in regulations, the term 'deferral ratio' means the ratio which the number of months in the deferral period of the applicable

election year bears to the number of months in the applicable election year.''.

(3) NET INCOME.—Paragraph (2) of section 7519(d) is amended by adding at the end the following new subparagraph:

''(D) EXCESS APPLICABLE PAYMENTS FOR BASE YEAR.—In the case of any new applicable election year, the net income for the base year shall be increased by the excess (if any) of—

''(i) the applicable payments taken into account in determining net income for the base year, over

''(ii) 120 percent of the average amount of applicable payments made during the first 3 taxable years preceding the base year.''

(4) DEFERRAL PERIOD.—Paragraph (1) of section 7519(e) (defining deferral period) is amended to read as follows:

''(1) DEFERRAL PERIOD.—Except as provided in regulations, the term 'deferral period' means, with respect to any taxable year of the entity, the months between—

''(A) the beginning of such year, and

''(B) the close of the first required taxable year (as defined in section 444(e)) ending within such year.''.

(5) BASE YEAR.—

(A) IN GENERAL.—Paragraph (2)(A) of section 7519(e) (defining base year) is amended to read as follows:

''(A) BASE YEAR.—The term 'base year' means, with respect to any applicable election year, the first taxable year of 12 months (or 52–53 weeks) of the partnership or S corporation preceding such applicable election year.''.

(B) CONFORMING AMENDMENT.—Paragraph (2) of subsection (g) of section 7519 is amended to read as follows:

''(2) there is no base year described in subsection (e)(2)(A) or no preceding taxable year described in section 280H(c)(1)(A)(i).''.

(c) INTEREST.—Section 7519(f)(3) (relating to interest) is amended to read as follows:

''(3) INTEREST.—For purposes of determining interest, any payment required by this section shall be treated as a tax, except that interest shall be allowed with respect to any refund of a payment under this section only for the period from the latest date

specified in subsection (c)(3) for such refund to the actual date of payment of such refund.''.

Subtitle H—Deduction for Charitable Contribution of Appreciated Property Limited To Adjusted Basis

SEC. 871. DEDUCTION FOR CHARITABLE CONTRIBUTION OF APPRECIATED PROPERTY LIMITED TO ADJUSTED BASIS.

(a) IN GENERAL.—The first sentence of section 170(e) (relating to contributions of ordinary income and capital gain property) is amended to read as follows: ''The amount of any charitable contribution of property otherwise taken into account under this section shall be reduced by the amount which would have been gain had the property been sold by the taxpayer at its fair market value (determined at the time of such contribution).''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 170 is amended by striking paragraphs (3), (4), and (5).

(2) Subsection (a) of section 57 is amended by striking paragraph (7).

(3) Subsection (c) of section 642 is amended by adding at the end thereof the following new paragraph:

''(7) LIMITATION ON DEDUCTION FOR CONTRIBUTION OF APPRECIATED PROPERTY.—''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions and gifts made after December 31, 1994.

Subtitle I—Minimum 5 Percent Rate of Tax on Interest Paid To Foreign Persons

SEC. 881. MINIMUM 5 PERCENT RATE OF TAX ON INTEREST PAID TO FOREIGN PERSONS.

(a) INDIVIDUALS.—

(1) Paragraph (1) of section 871(a) is amended by adding at the end thereof the following new sentence: ''Notwithstanding any treaty obligation of the United States, the rate of tax imposed under paragraph (1)(A) or (1)(C) shall not be less than 5 percent.''.

(2)(A) Paragraph (1) of section 871(h) (relating to repeal of tax on interest of nonresident alien individuals received from certain portfolio debt investments) is amended by striking ''no tax shall be imposed under paragraph (1)(A) or (1)(C) of subsection (a).'' and inserting ''the rate of tax imposed under paragraph (1)(A) or (1)(C) of subsection (a) shall be 5 percent. The preceding sentence shall

apply notwithstanding any treaty obligation of the United States.''.

(B) Paragraph (2) of section 861(h) is amended by striking ''which would be subject to tax under subsection (a) but for this subsection and'' and inserting ''subject to tax under subsection (a)''.

(C) The heading of section 871(h) is amended by striking ''REPEAL OF TAX'' and inserting ''5 PERCENT RATE OF TAX''.

(b) CORPORATIONS.—

(1) Subsection (a) of section 881 is amended by adding at the end thereof the following new sentence: ''Notwithstanding any treaty obligation of the United States, the rate of tax imposed under paragraph (1) or (2) shall not be less than 5 percent.''

(2)(A) Paragraph (1) of section 881(c) (relating to repeal of tax on interest of foreign corporations received from certain portfolio debt investments) is amended by striking ''no tax shall be imposed under paragraph (1) or (3) of subsection (a).'' and inserting ''the rate of tax imposed under paragraph (1) or (3) of subsection (a) shall be 5 percent. The preceding sentence shall apply notwithstanding any treaty obligation of the United States.''.

(B) Paragraph (2) of section 881(c) is amended by striking ''which would be subject to tax under subsection (a) but for this subsection and'' and inserting ''subject to tax under subsection (a)''.

(C) The heading of section 881(c) is amended by striking ''REPEAL OF TAX'' and inserting ''5 PERCENT RATE OF TAX''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to interest received after December 31, 1994, in taxable years ending after such date.

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